Alabama Medicaid Management Information System Provider Manual April 2024

Alabama Medicaid Provider Manual Distribution Change

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

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Bookmark Usage Instructions

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

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

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

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. Providers are urged to study it closely and update it as new material is supplied.

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

The Gainwell 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 Gainwell Provider Relations at the following address:

Gainwell Provider Relations
P.O. Box 241685
Montgomery, AL 36124-1685
1 (800) 688-7989
e-mail: alabamaproviderreps@gainwelltechnologies.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.

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1.1.1 Manual Organization

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

Part I – Provider Information

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

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

Part II – Alabama Medicaid Services

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

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

Part III – Appendices

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

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

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1.1.2 Tips for Using the Manual

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

Section Numbering and Page Numbering

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

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

Date Field

The bottom of each page contains a date field indicating when the page went to print. The date field includes the month and year of distribution (for instance, January 2004).

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.

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 online version of the manual features a search capability.

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Notes

Throughout this document, note boxes and margin notes emphasize important details, messages, or references to other sections in the manual. Because the manual will be updated periodically, note boxes and margin notes do not contain specific page references; rather, they contain section references as appropriate. This way, as updates are made 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

The billing manual is available in online format. 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

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

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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:** Intel 1.3GHz processor or equivalent, Microsoft Windows 2000 with Service Pack 4; Windows Server 2003, 2008, or 2008 R2; Windows XP Professional, Home Edition, or Tablet PC Edition with Service Pack 2 or 3 (32 bit and 64 bit); Windows Vista Home Basic, Home Premium, Business, Ultimate, or Enterprise with Service Pack 1 or 2 (32 bit and 64 bit); Windows 7 Starter, Home Premium, Professional, Ultimate, or Enterprise (32 bit and 64 bit), 128MB of RAM (256MB recommended), 335MB of available hard-disk space (additional space required for installation), Internet Explorer 7 or 8; Firefox 3.6 or 10 (ESR)
- **Macintosh System Requirements:** PowerPC® G4, PowerPC G5, or Intel processor, Mac OS X v10.4.11–10.5.8 (PowerPC); Mac OS X v10.4.11–10.6.3 (Intel), 128MB of RAM (256MB recommended), 405MB of available hard-disk space (additional space required for installation), Safari 3.0.4 or later

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.

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Acrobat Reader

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

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

Online *Alabama Medicaid Provider Manual*

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

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

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

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

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



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

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

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

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

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

Step 9 If the File Download dialog box displays, choose the Save the File to Disk option to save the manual to your PC. (You should save the manual to your hard drive, to CD, or to ZIP disk.

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

1.2.2 Benefits of Using the Online Manual

The following advantages will 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

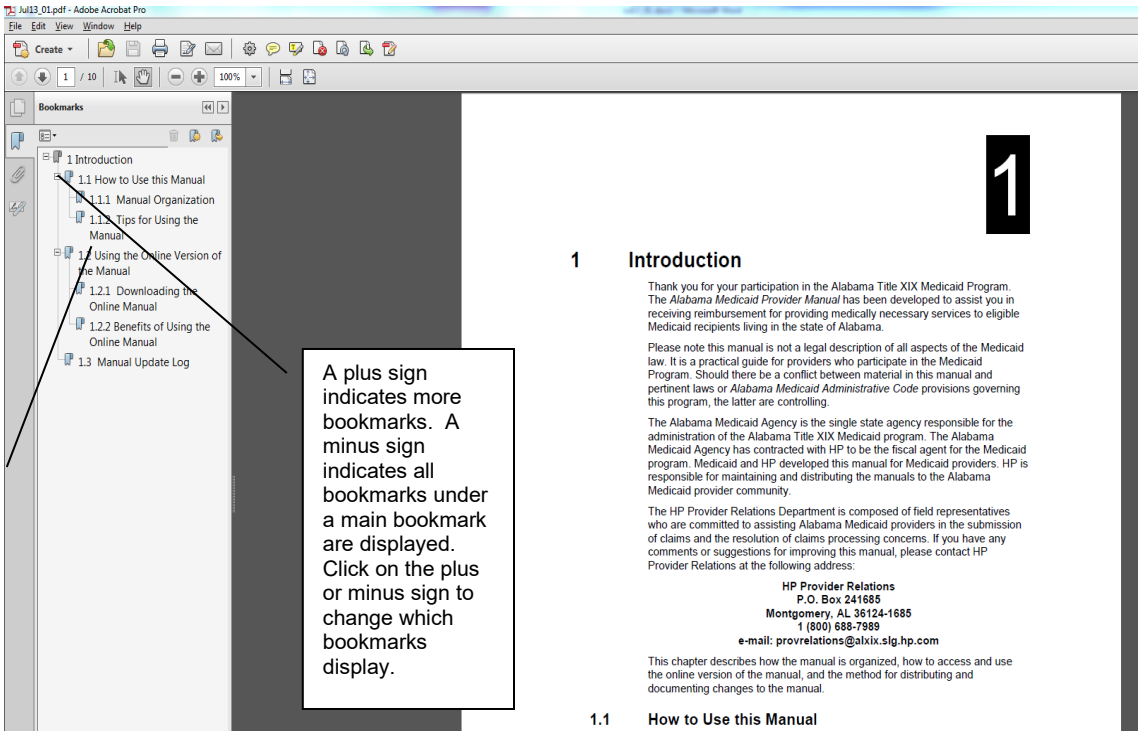
Although you cannot alter the contents of the online manual, you can modify how the manual displays online. Acrobat enables you to increase or reduce the font size, which can be helpful if you have vision problems. You may also customize other view options as available through the Acrobat Reader. The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

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



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

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

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

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

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

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1.3 Quarterly Updates

Gainwell makes updates to this Manual on a quarterly basis each year in:

- January
- April
- July
- October

Each quarter the entire Manual is posted on the Alabama Medicaid website at the following address: www.medicaid.alabama.gov.

The Alabama Medicaid Program policy published in this manual represents policy implemented as the publication date. Policy updates effective after publication, are published in ALERTS or in the *Alabama Medicaid Provider Insider* bulletin.

1.4 Copyright Disclaimer

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1.5 Alabama Medicaid Provider Number

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

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

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

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

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2 Becoming a Medicaid Provider

Gainwell 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, Gainwell receives and reviews all applications. Each application is approved, returned, or denied within ten business days of receipt.

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

Federal regulations require any provider who orders, prescribes, or refers services for a Medicaid recipient to be enrolled as a participating provider in the Medicaid program. An enrollment application for Ordering, Prescribing, and Referring (OPR) providers can be completed through the Provider Enrollment Application Portal on the Medicaid Agency's website at http://medicaid.alabama.gov.

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

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

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

2.1 Completing an Application

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

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

The Gainwell Provider Enrollment Department is responsible for processing the application. To access the application, providers go to the following website under Provider Enrollment and complete the online application: http://medicaid.alabama.gov.

NOTE:

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

All supplemental forms for enrollment for which a wet signature is not required may be submitted to Gainwell Provider Enrollment via an electronic submission. The below list of forms cannot be submitted electronically.

- EPSDT Agreement
- Plan First Program Agreement
- Telemedicine Services Agreement
- Attestation for Primary Care Rate Increase

Note: EFT forms require a wet signature but may be faxed.

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

NOTE:

Providers Who Have Obtained Medicare Approval

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

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

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2.2 Submitting the Application

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

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

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

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

Electronic Funds Transfer is required for reimbursement.

Providers must comply with Section 1104, Administrative Simplification, of the Affordable Care Act (Operating Rules), which requires Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA).

NOTE:

A provider who does not submit claims within a consecutive 18-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

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

- If the application is approved, Gainwell generates an enrollment notification letter listing the NPI number submitted by the provider and then mails the letter to the provider within two business days of approval.
- If the application is denied, Gainwell 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, Gainwell sends an email notification to the provider listing the necessary information Gainwell requires to complete the enrollment process.

When Gainwell 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, Gainwell logs the date returned.

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

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

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

2.4 Re-Validation

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

All supplemental forms for reenrollment for which a wet signature is not required may be submitted to Gainwell Provider Enrollment via an electronic submission. The below list of forms cannot be submitted electronically.

- Corporate Board of Directors Resolution
- Re-Validation Facsimile
- Provider Agreement
- EPSDT Agreement
- Alabama Coordinated Health Network (ACHN) Enrollment

2.5 Application Fees

Federal regulations require States to collect an application fee from all re-validating or newly enrolling institutional providers. States must collect this fee from institutional providers prior to enrollment or re-validation if these providers have not paid a fee to Medicare or another State or are not enrolled with Medicare, another State's Medicaid program, or CHIP. Physicians and non-physician practitioners are not subject to the fee. The application fee amount is established by CMS and is updated annually.

Institutional providers must submit the application fee in the form of a certified or cashier's check at the time of their initial enrollment or re-validation. The application fee should be mailed to Gainwell Provider Enrollment Department at P. O. Box 241685, Montgomery, Alabama 36124-1685. Those institutional providers who have paid the application fee to Medicare or another State or are enrolled with Medicare, another State's Medicaid program, or CHIP will be exempt from paying the fee to Alabama Medicaid. Providers may also request a hardship exception as needed. A hardship exception can be requested by submitting a letter along with supporting documentation to the fiscal agent. Medicaid will evaluate the request and submit the information to CMS only if Medicaid approves the exception.

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A complete list of providers required to submit a fee can be located on the Medicaid Agency website under the Provider tab.

2.6 Fingerprinting

Federal regulations require States to conduct a fingerprint based criminal background check (FCBC) on providers or any person with 5 percent or more direct or indirect ownership interest in the provider who meet any of the criteria below pursuant to 42 C.F.R. § 455.450.

1. Providers whose screening categorical risk level is set at “high”.
2. Providers whose screening categorical risk level has been adjusted to “high” due to a payment suspension based on a credible allegation of fraud, waste, or abuse.
3. Providers whose screening categorical risk level has been adjusted to “high” because they have an existing Medicaid overpayment.
4. Providers who have been excluded by the Office of Inspector General or another State’s Medicaid program within the previous 10 years.
5. Providers who were prevented from enrolling during a state or federal moratorium and apply for enrollment as a provider at any time within 6 months from the date the moratorium was lifted.

FCBCs will be conducted at the following times:

- Initial enrollment - All providers designated as a “high” categorical risk will be screened for an FCBC. If an FCBC has already been conducted by Medicare, Alabama Medicaid may be able to rely on Medicare’s information.
- Currently enrolled providers – These providers will be requested to complete an FCBC at the time their risk level is elevated to “high”.
- Application for enrollment by previously sanctioned providers – After a provider’s sanction has been lifted, they will be required to complete an FCBC before again enrolling in the Alabama Medicaid program.

Providers who are required to submit to an FCBC will be notified individually by letter requesting them to visit the Alabama Law Enforcement Agency or their nearest law enforcement agency within 30-days from the date of their notification letter to submit their fingerprints for processing. The Medicaid Agency will supply the provider with all necessary documentation to complete the fingerprint process.

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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 may be considered when determining Medicaid eligibility.

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

NOTE:

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

This chapter consists of three sections:

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

3.1 General Medicaid Eligibility

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

3.1.1 Granting Eligibility

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

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

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

3.1.2 Eligibility Criteria

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

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

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

NOTE:

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

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3.1.3 Valid Types of Recipient Identification

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

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

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

NOTE:

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

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

Recipient Identification (RID) Number

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

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

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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. If for some reason the recipient has multiple RID's that are not linked, contact the Gainwell Provider Assistance Center at 1 (800) 688-7989 to verify the correct RID for claims submission.

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
- Two-digit card number

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

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

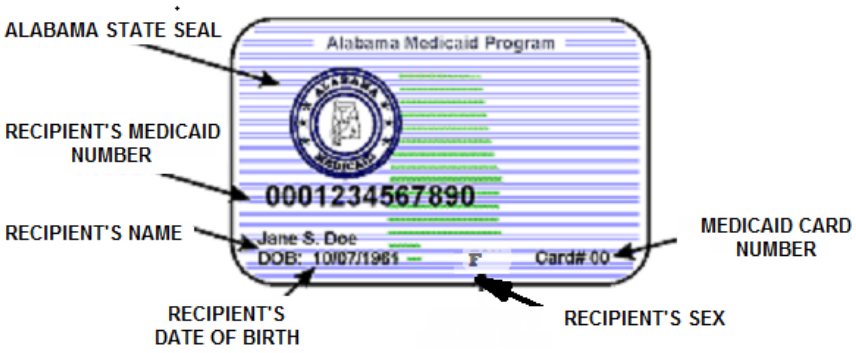
Providers should check the two-digit card number against the card number returned as part of the eligibility verification response. The first card issued has a number of '00'; the second, '01'; and so on. If the numbers do not match (for instance, if the plastic card number is '00' but the eligibility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

NOTE:

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

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Below is a sample Medicaid card:

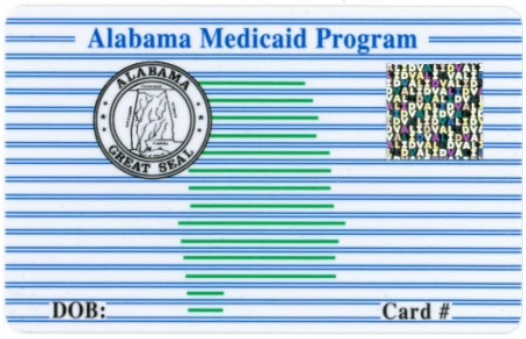


New Medicaid Cards to Contain a Security Hologram

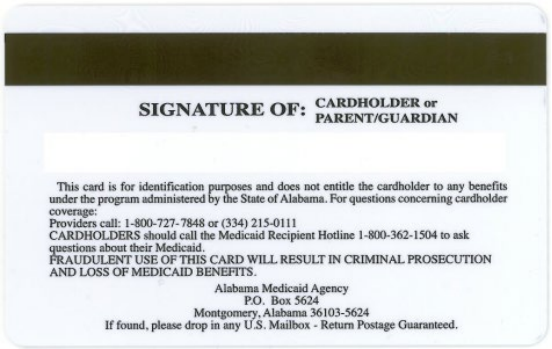
Beginning in June 2011, Medicaid cards will contain a hologram which will be located in the upper right corner. This hologram is designed to make card replication more difficult. New cards will only be issued upon recipient request. Medicaid IS NOT issuing new cards to all recipients.

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

Front



Back



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Notification Letters

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

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

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

Eligibility Notification Letter for Newborns/Unborns

Alabama Medicaid Agency

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

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

OCTOBER 1, 1999

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

MEDICAID: 000-555-05-5555-1

Dear UNBORN C DOE,

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

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

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Eligibility Notification Letter for Recipients without a Social Security Number

Alabama Medicaid Agency
501 Dexter Avenue
P.O. Box 5624
Montgomery, Alabama 36103-5624
www.medicaid.state.al.us
e-mail: almedicaid@medicaid.state.al.us

DO NOT THROW AWAY THIS MEDICAID LETTER

OCTOBER 1, 1998

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

Dear TEST A. RECORD,

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

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

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Eligibility Notification for Recipients with Closed or Retroactive Eligibility

Alabama Medicaid Agency

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

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

OCTOBER 1, 1999

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

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

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

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

Retroactive Eligibility Issued Within the Last 12 Months:

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

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

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Eligibility Notification for Recipients in Nursing Homes

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

A sample list displays below:

Alabama Medicaid Agency

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

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

OCTOBER 1, 1999

STATE OF ALABAMA
ALABAMA MEDICAID AGENCY
501 DEXTER AVENUE

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

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

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

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

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

NOTE:

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

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3.2 Confirming Eligibility

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

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

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

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

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

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

If the claim denies for ineligibility, the provider may contact the Gainwell 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 Gainwell
- Automated Voice Response System (AVRS) at 1 (800) 727-7848
- Contacting the Gainwell Provider Assistance Center at 1 (800) 688-7989
- Web Portal https://www.medicaid.alabamaservices.org/ALPortal

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

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

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

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

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NOTE:

Calling Gainwell 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
- Benefit Limits
- Dental Benefit Limits

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

3.3.1 Alabama Recipient Aid Categories

NOTE:

Programs such as Managed Care and 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.**

Pregnancy Coverage

Effective 11/1/2015, pregnant women aid categories (5A, 5B, 5C, R4, R5) service coverage was changed from pregnancy related coverage to full coverage Medicaid for pregnancy and non-pregnancy related services throughout pregnancy and through the end of the month of the postpartum period. (Co-pays will apply for non-pregnancy related services.)

5A SOBRA pregnant women - covered for full Medicaid through the last day of the 12th postpartum month.

5B SOBRA pregnant women – covered for full Medicaid with QMB through the last day of the 12th postpartum month.

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5C SOBRA pregnant women – covered for full Medicaid with Medicare through the last day of the 12th postpartum month.

R4 Retro - SOBRA pregnant woman/covered for Full Medicaid through the last day of the 12th postpartum month.

R5 Retro - SOBRA pregnant woman covered for full Medicaid with QMB through the last day of the 12th postpartum month.

Partial Coverage

The following aid categories denote partial coverage:

50 Family planning-related services only for females 19-55. Sterilization only for males age 21 and older, effective 8/1/2015.

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)

PW Women determined presumptively eligible for ambulatory (walk-in), services only. Inpatient services not covered

Emergency Services Only Coverage

58 Pregnant Non-Citizens – covered for pregnancy and non-pregnancy related emergency services throughout pregnancy and through the last day of the 12th postpartum month.

R6 Retro-Pregnant Non-Citizens covered for pregnancy and non-pregnancy related emergency services throughout pregnancy and through the last day of the 12th postpartum month.

EC Non-citizen child, Emergency services only*

ED Non-citizen child, Emergency services only*

EY Non-citizen child, Emergency services only*

EK Non-citizen child, Emergency services only*

EP Non-citizen adult, Emergency services only*

New emergency service eligibility categories EC, ED, EY, EK, and EP for non-citizens were added effective 1/1/2014. Recipients will receive a Medicaid number and plastic card allowing for normal claims filing by the provider instead of the former manual process. All emergency services aid categories listed above cover the following emergency services:

- Hospital – Inpatient –up to 3 days and/or the day of discharge
- Hospital – Outpatient
- Physician
- Lab and X-ray

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- Ambulatory services
- No pharmacy benefits effective 7/1/15
- Pregnancy emergencies and/or delivery

Effective 7/1/15, no pharmacy benefits available for the following aid categories: EC, ED, EY, EK, EP, R6, and 58.

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	R5
15	25	33	45	57	R8*
17	27	35	47	59	75
1E	2A	37	4A	5B	76
	2E	3C	4E	5H	78
		3D	4Q	5L	7Q
		3H	SQ	R3	86
		3K	TQ*		

Category 3: See the description of Category 3 recipients in Section 3.3.6, Medicare.

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

12	22	3E	42	5C
13	23	3F	43	5D
18	28	3L	48	5J
1D	2B	3M	4B	5M
	2D		4D	R9
			4L	79
			SL	
			TL*	

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

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Special Coverage

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

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

TT-R7 Full Medicaid plus private duty nursing services

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

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

No Coverage

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

3.3.2 Lock-in

The Alabama Medicaid Agency closely monitors program usage to identify recipients who may be potentially overusing or misusing Medicaid services and benefits. For those identified recipients, qualified Alabama Medicaid staff performs medical desk reviews to determine overuse and/or misuse of services. 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 letter of the pending restriction. They are asked to contact the Recipient Review Unit or the Clinical Services and Support Division 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 or the Clinical Services and Support Division 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 Alabama Medicaid Agency Referral Form (Form 362) when referring the restricted recipient to another physician. 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. This form can be obtained by accessing Medicaid's website.

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NOTE:

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

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 plan status.

Refer to Chapter 40, ACHN, for more detailed information about managed care programs.

Medicaid's Medicare Advantage Managed Care Plan

There are currently 11 companies that contract with the Alabama Medicaid Agency and offer Medicare Advantage coverage in Alabama – Aetna Better Health, Aetna Life Insurance Company, Arcadian Health Plan (A Humana company), Care Improvement Plus South Central Insurance Company (A UnitedHealthCare company), Devoted Health Plan of Alabama, HealthSpring Life & Health Insurance Company (CIGNA), Humana Insurance Company, Simpra Advantage, UnitedHealthcare of the Midlands, VIVA Health, and Wellcare of Alabama. Medicaid makes a per member per month capitation payment to the applicable plan when the recipient is enrolled in one of the above contracted plans and meets all applicable criteria. This payment covers all Medicare co-payments, deductibles and coinsurance. Therefore, neither Medicaid nor the recipient will pay any co-payments, deductibles or coinsurance for Medicare services incurred during the time that the individual is enrolled in Medicaid's Medicare Advantage Plan.

Claims can be submitted to Medicaid for copays, deductibles or coinsurances for dates of service that are outside the dates that Medicaid has paid a per member per month capitation to one of the plans listed above. These claims should be billed on a Medicare/Medicaid crossover claim and will be processed like any other Medicare paid claim. (See Section 5.6.2 for specific billing instructions)

There are several Medicare Advantage Plans that are servicing Medicaid recipients. However, the Plans mentioned above are the only ones with whom Medicaid has a contract to make per member per month capitation payments. Since Medicare Advantage Plans pay in place of Medicare, any secondary claims to Medicaid for copays, deductibles or coinsurance should be billed on a Medicare/Medicaid crossover claim and will be processed by Medicaid in the same manner as a Medicare paid claim. (See Section 5.6.2 for specific billing instructions)

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

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

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

3.3.4 Benefit Limits

The Alabama Medicaid Agency establishes annual benefit limits on certain covered services. When the recipient has exhausted his or her benefit limit for a particular service, providers may bill the recipient.

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 who have full Medicaid benefits.

NOTE:

Aid Categories 50, 58 and R6 are not covered under EPSDT.

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

Benefit	***Limitation***
Physician office visits	14 per year
Eyeglass frames	One per two calendar years for recipients age 21 and older. Two pair per calendar year for recipients under age 21.
Eyeglass lenses	One per two calendar years for recipients age 21 and older. Two pair per calendar year for recipients under age 21.
Eyeglass fitting exams	1 exam every two years for recipients 21 years and older; one exam per calendar year for recipients under age 21.
Eyeglass exams	1 exam every two years for recipients 21 years and older; one exam per calendar year for recipients under age 21.
Home health visits	104 per year
Ambulatory surgery center	3 per year
Dialysis services	156 per year

NOTE:

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

3.3.5 Dental Benefit Limits

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

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

Benefit	***Limitation***
Dental Space Maintainer	2 per lifetime under 20 years, 3rd with PA

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Benefit	*Limitation*
Dental Fluoride	<3 1 per 6 months >3 1 per 6 months
Dental Prophylaxis	1 per 6 months
Full or Panoramic Xray	1 per 3 years
Oral Exam	1 per 6 months
Oral Evaluation < 3 years of age	1 per year
Fluoride Varnish < 3 years of age	3 per calendar year
Fluoride Varnish > 3 years of age	1 per calendar year
Periapical Xray	5 per calendar year; limited to one per date of service when used in conjunction with a bitewing X-ray
Bitewing Xray	1 per 12 months

3.3.6 Medicare

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

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

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

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

3.3.7 Third Party Liability

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

NOTE:

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

This section discusses the following:

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

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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, if necessary. Medicaid payment may be denied or recouped retroactively if the recipient's health plan requirements are not met.

Verifying Other Insurance

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

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

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

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

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

NOTE:

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

A through F – 334/242-5249

G through L – 334/353-5773

M through R – 334/242-5280

S through Z – 334/242-5254

You may also report coverage changes by going to Medicaid's website and completing an email or faxable form to update health insurance: http://medicaid.alabama.gov/content/7.0_Providers/7.1_Third_Party.aspx. Select: **Update Health Insurance Information** to choose the preferred method to report the change.

Submitting Claims to Other Insurance

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

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

Medicare Crossover Claims

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

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

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Duplicate Payment by a Third Party

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

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

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

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

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

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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
- Submitting prior authorization supporting documentation
- 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.

Refer to Chapter 22 Independent Radiology, for information regarding prior authorization for Radiology and Cardiology services. Providers performing the following services on or after March 2, 2009, requires a prior authorization from eviCore.

- Magnetic Resonance Imaging (MRI)
- Magnetic Resonance Angiogram (MRA)
- Computed Tomography (CT)
- Computed Tomography Angiogram (CTA)
- Positron Emission Tomography (PET) scans

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- Nuclear Cardiology
- Diagnostic Heart Catheterization
- Stress Test (ECHO)
- Transesophageal ECHO
- Transthoracic ECHO

Inpatient hospital service, emergency room service, Plan First, SOBRA Adult and Medicaid/ Medicare are exempt from the PA requirement.

Send PA request for outpatient diagnostic imaging procedure to eviCore by:

Phone at (855) 774-1318

Fax at (888) 693-3210

Website at www.evicore.com

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

NOTE:

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

NOTE:

For SOBRA adult recipients who now have full Medicaid benefits, retroactive to November 1, 2015, providers may submit a PA for a date of service on or after November 1, 2015 if the procedure code requires a PA. For dates of service from November 1, 2015 to April 30, 2016, the PA must be received by Gainwell by June 30, 2016 for review. All other PAs for a date of service May 1, 2016 and after must be submitted timely, prior to rendering the service, and adhere to the normal submission guidelines in this Chapter and other applicable Chapters, such as Chapter 14, Durable Medical Equipment

4.2 Submitting a Prior Authorization Request

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

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

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NOTE:

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

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

It is the responsibility of the physician to obtain prior authorization for any outpatient surgical procedure to be performed in an outpatient hospital or ambulatory surgical center **prior to rendering the service**, unless it is a medical emergency, as explained below.

PAs for radiation treatment and/or management services must be requested within 30 days of providing the service.

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

Prior authorizations must be received by the fiscal agent within 30 days of dispensing equipment, providing vision services, or for laboratory procedures within 30 days of the date of service.

A Letter of Medical Necessity (LMN) with sufficient information to meet criteria may be submitted. However, medical records may be requested to justify the medical necessity of the requested item or service by the Agency or its designated PA reviewer.

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

Prior authorization requests that are received by Gainwell and rejected due to incorrect information will not be considered received timely unless resubmitted correctly within 30 days of the dispensed date.

Providers shall verify that procedure codes requested on a PA are not subject to NCCI edits, whether procedure to procedure (PTP), or medically unlikely (MUE) edits. An approved PA may not override an NCCI edit.

Providers shall review NCCI edits on the CMS site at, https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index, prior to submitting a PA.

4.2.1 Submitting PAs Using Provider Electronic Solutions

Providers can submit electronic PA requests using Gainwell Provider Electronic Solutions software available at no charge. Gainwell will mail the software to the provider at no cost, or the provider may download the software from the Internet.

http://medicaid.alabama.gov/content/7.0_Providers/7.8_PES_Software.aspx

Refer to Chapter 15 of the *Provider Electronic Solutions Manual* for specific information. This chapter provides instructions for submitting electronic 278 requests

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The electronic 278 Health Care Services Review- Request for Review and Response claim is not limited to the use of the Provider Electronic Software. Providers may use other vendor's software to submit a 278 electronic claim.

NOTE:

Please include a copy of the Prior Authorization response, which is received after your submission, with your PA supporting documentation. For details, refer to section 4.3 PA Requests Requiring Supporting Documentation on submitting PA supporting documentation using the Web Portal.

4.2.2 Submitting Paper PA Requests

PAs should be submitted via hard copy (paper) only when the medical documentation cannot be uploaded electronically, such as instances where photos, radiographs or x-rays must be submitted and the provider does not have scanning ability to upload the documentation. PAs that are submitted via hard copy (paper) outside of these instances will not be reviewed. Completed paper applications should be sent to the following address:

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

For a hardcopy request, the provider or authorized representative must personally sign the form in the appropriate area to certify that the requested service, equipment, or supply is medically indicated and is reasonable and necessary for the treatment of the patient. For electronic signatures, provider certification shall be in accordance with the electronic signature policy in the Administrative Code, Chapter 1, Rule No. 560-X-1-.18 Provider/Recipient Signature Requirements.

Note: Paper requests should be submitted ONLY for PAs requiring photos/x-rays.

4.2.3 Submitting PA Requests Using the Web Portal

Providers may also submit PA requests through the interactive web portal. Please use this link for the Alabama Medicaid Agency AMMIS Interactive Services Website User Manual:
http://medicaid.alabama.gov/content/7.0_Providers/7.6_Manuals.aspx

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

4.3 PA Requests Requiring Supporting Documentation

If supporting documentation is required for PA review, the required attachments must be sent to Gainwell within 48 hours to be scanned into the system to prevent a delay in review and/or a denial for "no documentation" to support the PA request. Do not fax this information to the Alabama Medicaid Agency unless a request is made for specific information by the Agency reviewer. Attachments scanned can be located in the system and are linked by the PA number on the Prior Authorization response returned by the system.

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This section describes how to submit PA supporting documentation using the Web Portal, and includes the following sections:

- Submitting PA Supporting Documentation Using the Web Portal
- Instructions for Submitting PA Supporting Documentation using the Web Portal

4.3.1 Submitting PA Supporting Documentation Using the Web Portal

Providers will be able to upload or fax PA supporting documentation via the Forms menu of the Alabama Medicaid Interactive Web Portal starting:

- July 18, 2016 for Medical PA support documentation
- August 18, 2016 for Dental PA supporting documentation

Effective May 1, 2017, Alabama Medicaid will only allow the electronic upload and submission of Medical and Dental PA (including Hospital Dental PA) supporting documentation **(including Reconsideration)** via the web portal. Medical and Dental PA supporting documentation (including Reconsideration) received on paper after that date will be returned to the provider with the exception of paper/original Photos, Radiographs, and X-Ray images.

A form will allow providers the ability to upload Medical or Dental PA supporting documents in PDF format or create a fax barcode coversheet from the Web Portal. Providers may submit additional documentation via fax or electronic upload at a later time and have that documentation combined with the original document through the use of the same PA number.

NOTE:

Instructions for submitting additional documentation via fax:

Fax the required documentation with the provided barcode coversheet on top of the documentation to 334-215-7416

The bar code cover sheet is required for each fax submission for the same recipient. A fax submission cannot be processed without the bar coded cover sheet. **DO NOT** place anything on the bar code on the cover sheet or alter it in any manner.

Do not fax double sided pages.

Do not fax multiple sets of records at the same time. Each fax should be sent separately.

The bar code cover sheet is unique to this transaction. To submit documentation for another recipient, please complete the process for that unique recipient transaction.

A **new** bar code cover sheet should be generated when uploading/faxing documents for a reconsideration of a denied PA, using the original PA number.

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NOTE:

Please note the submission process for paper/original Dental X-Ray/Radiograph images will remain as it occurs today. Refer to Chapter 13 (Dentist) of this manual for details.

NOTE:

Please note the submission process for paper/original Photos, Radiographs, and X-Ray images will remain as it occurs today for the following PA requests:

15-04 – Reduction mammoplasty

15-06 – Reconstruction vs. Cosmetic Procedures

15-07 – Blepharoplasty

15-08 - Abdominoplasty

4.3.2 Instructions for Submitting PA Supporting Documentation Using the Web Portal

Please use this link for the Alabama Medicaid Agency AMMIS Interactive Services Website User Manual:
http://medicaid.alabama.gov/content/7.0_Providers/7.6_Manuals.aspx

See Section 13.6.1 of the AMMIS Interactive Services Website User Manual, Forms Panel, for information about this process.

4.4 Completing the Alabama Prior Review and Authorization Request Form

Providers use the Alabama Prior Review and Authorization Request Form to submit Medical PAs on paper. This form is available through the Medicaid Agency at the following website link:

http://medicaid.alabama.gov/content/9.0_Resources/9.4_Forms_Library.aspx

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4.4.1 Blank Alabama Prior Review and Authorization Request Form

You may fill in the blanks on the computer. Print the form and add signature and date. Mail completed form to HPE at the address below. Information that is typed in will not be saved in the form once the document is closed.

ALABAMA PRIOR REVIEW AND AUTHORIZATION REQUEST

(Required if Medicaid Provider) PMP ( )
Requesting Provider NPI #
Phone with Area Code
Name

Recipient Medicaid #
Name
Address
City/State/Zip
EPSDT Screening Date DOB
Prescription Date CCYYMMDD

Rendering Provider NPI #
Phone with Area Code
Fax with Area Code
Name
Address
City/State/Zip
Ambulance Transport Code
Ambulance Transport Reason Code
DME Equipment: New Used

First Diagnosis . Second Diagnosis .
Assignment/Service Code Patient Condition Prognosis Code

01	Medical Care	A4	Home Health Visits	AD	Occupational Therapy
02	Surgical	54	LTC Waiver	AE	Physical Therapy
12	DME-Purchase	55	Medically-Related Transportation		
19	DME-Rental	69	Maternity	A4	Psychiatric*
38	Dental Care	73	Inhalation Therapy	AF	Speech Therapy
40	Oral Surgery	74	Private Duty Nursing	A4	Vision-Optometry
41	Home Health Care	75	Prosthetic Device	CM	Case Management

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

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

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

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

Signature of Requesting Provider Date

FORWARD TO: HPE, P.O. Box 244036 Montgomery, Alabama 36124-4032

Form 342
Revised 4-2018

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Alabama Medicaid Agency
www.medicaid.alabama.gov

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

Section 1: Requesting Provider Information (Required)

Alabama Coordinated Health Network (ACHN) / PCP	Refer to recipient's prescribing physician for Prior Authorization.
License # or NPI	Enter the license number or the National Provider Identifier (NPI) of the physician requesting or prescribing services.
Phone	Enter the current area code and telephone number for the requesting physician.
Name	Enter the name of the prescribing physician.

Section 2: Rendering Provider Information (Required)

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

Section 3: Recipient Information (Required)

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

Section 4: Other Information

EPSDT Screening Date CCYYMMDD	**Required field for all requests.** Enter the date of the last EPSDT screening. Enter dates using the format CCYYMMDD. Example: October 1, 1999 would be 19991001.
DOB	Enter the date of birth of recipient.
Prescription Date CCYYMMDD	**Required field for all requests.** Enter the date of the prescription from the attending physician. Enter dates using the format CCYYMMDD. Example: October 1, 1999 would be 19991001.
First Diagnosis	**Required field for all requests.** Enter the primary diagnosis code.
Second Diagnosis	Enter the secondary diagnosis code.
Service Type	**Required field for all requests.** Outpatient hospitals requesting physical therapy must use Service type 01 (medical) and not Service Type AE (physical therapy.).

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Patient Condition	Enter the code that best describes the patient's condition. Refer to "Patient Condition Codes" in the section below for appropriate codes. **Used for non-emergency ground transport, > 100 miles, ambulance services and DME providers only.**
Prognosis Code	**Required field for Service Types: 42, 44, and 74.**

Section 5: Procedure Information (Required)

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

NOTE:

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

Procedure Code Modifiers

Procedure code modifiers are not available with the current electronic 278 Health Care Services Review – Request for Review transaction. Procedure codes requiring anatomic modifiers such as "right" and "left" should be requested on separate lines on the PA request. Refer to the July 2013 Provider Insider for information about the correct use of modifiers. (www.medicaid.alabama.gov. Select Providers and then News & Notices).

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.

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

Patient Condition Codes

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

Code	*Description*
01	Patient was admitted to a hospital
02	Patient was bed confined before the ambulance service
03	Patient was bed confined after the ambulance service
04	Patient was moved by stretcher
05	Patient was unconscious or in shock
06	Patient was transported in an emergency situation
07	Patient had to be physically restrained
08	Patient had visible hemorrhaging
09	Ambulance service was medically necessary
10	Patient is ambulatory
11	Ambulation is impaired and walking aid is used for therapy or mobility
12	Patient is confined to a bed or chair
13	Patient is confined to a room or an area without bathroom facilities
14	Ambulation is impaired and walking aid is used for mobility
15	Patient condition requires positioning of the body or attachments which would not be feasible with the use of an ordinary bed
16	Patient needs a trapeze bar to sit up due to respiratory condition or change body positions for other medical reasons
17	Patient's ability to breathe is severely impaired
18	Patient condition requires frequent and/or immediate changes in body positions
19	Patient can operate controls
20	Side rails are to be attached to a hospital bed owned by the beneficiary
21	Patient owns equipment
22	Mattress or side rails are being used with prescribed medically necessary hospital bed owned by the beneficiary
23	Patient needs lift to get in or out of bed or to assist in transfer from bed to wheelchair
24	Patient has an orthopedic impairment requiring traction equipment which prevents ambulation during period of use
25	Item has been prescribed as part of a planned regimen of treatment in patient's home
26	Patient is highly susceptible to decubitus ulcers
27	Patient or a caregiver has been instructed in use of equipment
28	Patient has poor diabetic control
29	A 6-7 hour nocturnal study documents 30 episodes of apnea each lasting more than 10 seconds
30	Without the equipment, the patient would require surgery

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Code	*Description*
31	Patient has had a total knee replacement
32	Patient has intractable lymphedema of the extremities
33	Patient is in a nursing home
34	Patient is conscious
35	This feeding is the only form of nutritional intake for this patient
37	Oxygen delivery equipment is stationary
38	Certification signed by the physician is on file at the supplier's office
39	Patient has mobilizing respiratory tract secretions
40	Patient or caregiver is capable of using the equipment without technical or professional supervision
41	Patient or caregiver is unable to propel or lift a standard weight wheelchair
42	Patient requires leg elevation for edema or body alignment
43	Patient weight or usage needs necessitate a heavy duty wheelchair
44	Patient requires reclining function of a wheelchair
45	Patient is unable to operate a wheelchair manually
46	Patient or caregiver requires side transfer into wheelchair, commode or other
58	Durable Medical Equipment (DME) purchased new
59	Durable Medical Equipment (DME) Is under warranty
5A	Treatment is rendered related to the terminal illness
60	Transportation was to the nearest facility
68	Severe
69	Moderate
9D	Lack of appropriate facility within reasonable distance to treat patient in the event of complications
9E	Sudden onset of disorientation
9F	Sudden onset of severe, incapacitating pain
9H	Patient requires intensive IV therapy
9J	Patient requires protective Isolation
9K	Patient requires frequent monitoring
AA	Amputation
AG	Agitated
AL	Ambulation limitations
BL	Bowel limitations, bladder limitations, or both (incontinence)
BPD	Beneficiary is partially dependent
BR	Bedrest BRP (bathroom privileges)
BTD	Beneficiary is totally dependent
CA	Cane required
CB	Complete bedrest
CM	Comatose
CNJ	Cumulative injury
CO	Contracture
CR	Crutches required
DI	Disoriented
DP	Depressed
DY	Dyspnea with minimal exertion
EL	Endurance limitations
EP	Exercises prescribed
FO	Forgetful
HL	Hearing limitations
HO	Hostile

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Code	*Description*
IH	Independent at home
LB	Legally blind
LE	Lethargic
MC	Other mental condition
NR	No restrictions
OL	Other limitation
OT	Oriented
PA	Paralysis
PW	Partial weight bearing
SL	Speech limitations
TNJ	Traumatic injury
TR	Transfer to bed, or chair, or both
UN	Uncooperative
UT	Up as tolerated
WA	Walker required
WR	Wheelchair required

Patient Assignment Codes

Use this table to determine the appropriate patient assignment code.

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

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

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

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

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4.4.3 Requesting a Revision to a Prior Authorization

Providers may request a change to a prior authorization for DME and certain medical services by completing Form 471. The Form may **not** be used for pharmacy PAs. Prior authorizations, for which a claim has been paid, may not be revised until the claim has been voided. The form is to be used for PA requests in evaluation status or for simple changes to an approved PA, such as adding appropriate modifiers. **The form is NOT to be used for reconsiderations of denied PAs or for procedure code changes**. Please refer to Section 4.5, Receiving Approval or Denial of a Request, for information about submitting a request for reconsideration. Providers may submit a new PA for procedure code changes. Complete the appropriate sections on the form **and fax to the Alabama Medicaid Agency's Prior Authorization designee, at (833) 536-2134 or (833) 536-2136 for DME, surgical, vision, ambulance and PDN PAs ONLY.** The form may be accessed at: http://medicaid.alabama.gov/content/9.0_Resources/9.4_Forms_Library.aspx

- For dental PAs, fax to: (334) 353-3426
- For radiology, or cardiology, or ABA therapy- related PAs, fax to: (334) 353-2309.
- For targeted case management PAs, fax to: (334) 215-7416

For a recipient who has a Medicaid ID change during an authorized PA period, the provider should submit a new PA with the active Medicaid ID. The requested effective date should be the effective date of the Medicaid ID. The requested end date must be the same authorized end date of the previous PA. Document the old and new PA numbers in the "Comments" section. Under "Reason for Change, Other:" document, "recipient Medicaid ID change." The new PA with the balance of units and the same authorized end date will be approved after the information has been verified. **These Form 471s should be faxed to the Agency** at (334) 353-4909, or to Sheila McDaniel at (256) 890-3155.

Please allow five business days for processing the Form 471.

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4.4.4 Blank Alabama Prior Authorization Change Request Form

Alabama Medicaid Agency
Prior Authorization (PA) Change Request

Supplier Information	
Contact Name:	
NPI:	
Phone Number:	

Recipient Information	
Recipient Name:	
Medicaid ID:	

Prior Authorization Number	

Reason for Change ***Please use this section to denote what field(s) on the PA request require a change. Complete all applicable fields below.*** ***Examples: Add/Change Modifier: Add "RR" to "E1088"*** ***Correct Date(s) of Service: Change requested effective date from 08/01/2010 to 10/01/2010***	
Add/Change Modifier:	
Correct Number of Service(s):	
Correct Place of Service:	
Correct Diagnosis Code(s):	
Correct Date(s) of Service:	
Correct NPI:	
Other: (Please Explain)	
Comments	

NOTE: *The Alabama Medicaid Agency cannot revise a PA for which a claim has already been paid. The paid claim must be voided before the PA can be changed. This form* ***must be received within 90 days*** *of the date of the approval on the PA decision letter.* ***The form is to be used for PA requests in evaluation status or for simple changes to an approved PA, such as adding appropriate modifiers. The form is NOT to be used for reconsiderations of denied PAs; for procedure code changes, or for pharmacy PAs.***

- **For DME, surgical, vision, ambulance and PDN PAs ONLY, fax to (833) 536-2134 or (833) 536-2136**
- **For dental PAs, fax to: (334) 353-3426**
- **For radiology, cardiology, or ABA (Applied Behavior Analysis) therapy related PAs, fax to: (334) 242-0533**
- **For TCM (targeted case management), fax to: (334) 215-7416**

Form 471 Alabama Medicaid Agency Revised: 09/30/2021 www.medicaid.alabama.gov

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4.4.5 Blank Alabama Prior Review and Authorization Dental Request Form

ALABAMA PRIOR REVIEW AND AUTHORIZATION DENTAL REQUEST

Section I – Must be completed by a Medicaid provider.

Requesting NPI or License #_____

Phone ( ) _____

Name _____

Address _____

City/State/Zip _____

Medicaid Provider NPI # _____

Section II

Medicaid Recipient Identification Number _____

(13-digit RID number is required)

Name as shown in Medicaid system _____

Address _____

City/State/Zip _____

Telephone Number ( ) _____

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

Section IV

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

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

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

_____

_____

_____

_____

3. Brief Dental/Medical History: _____

_____

_____

_____

_____

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

Signature of Requesting Dentist _____ Date of Submission _____

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

Form 343
Revised 5/28/13

Alabama Medicaid Agency
www.medicaid.alabama.gov

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

Section 1: Requesting Provider Information (Required)

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

Section 2: Recipient Information (Required)

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

Section 3: Procedure Information

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

Section 4: Medical Information

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

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

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

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

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4.5 Receiving Approval or Denial of the Request

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

Section 1: Decision Codes

Current Decision Codes:	
A	Approved
E	Evaluating
D	Denied
K	Cancelled
M	Modified PA Request
P	Pending
F	Denied Need Further Doco
G	Reconsideration

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

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

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

For PA requests submitted initially on paper, using Form 342:

Requests for reconsideration of a denied request may be sent with additional information that justifies the need for requested service(s). Providers should fax or mail the PA denial letter to Gainwell, along with the supporting documentation for reconsideration. It is recommended that the PA number be written at the top of each page of the reconsideration documents. Providers should refer to Section 4.2.1 for the Gainwell fax number and mailing address.

For PA requests submitted electronically:

Requests for reconsideration of a denied request may be electronically uploaded using the same process as for the initial upload of the supporting documentation. Please refer to Section 4.3 PA Requests Requiring Supporting Documentation for information about this process.

NOTE:

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

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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, then AVRS prompts you for the following:

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

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

- Recipient number
- Procedure code or NDC, if applicable (some PAs do not require procedure codes or NDCs)
- Start and stop dates
- Units authorized
- Dollars Authorized
- Units used
- Dollars Used

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

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

4.7 Submitting Claims for Prior Authorized Services

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

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5 Filing Claims

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

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

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

This chapter contains the following sections:

- *Before You Submit Your Claim,* which describes how claims are processed, which claim forms are approved for submission to Medicaid, and other general claim-related information
- *Completing the CMS-1500 Claim Form*, which provides detailed billing instructions for the CMS-1500 claim form
- *Completing the UB-04 Claim Form*, which provides detailed billing instructions for the UB-04 claim form
- *Completing the ADA Dental Claim Form*, which provides detailed billing instructions for the ADA Dental claim form
- *Completing the Pharmacy Claim Form*, which provides detailed billing instructions for the Pharmacy claim form
- *Crossover Claim Filing*, which provides billing instructions for the medical claim form. **Please note that for an administrative or manual review Alabama Medicaid requires paper crossovers for professional claims to be submitted using the approved Medical Medicaid/Medicare-related crossover claim form. Institutional providers should use the UB-04 claim form for crossovers.**

The crossover claim is also to be used to file claims in which the primary payer is a Medicare Advantage plan. When a recipient is enrolled in a Medicare Advantage plan and Medicaid has **not** paid a monthly capitation payment, providers must file a crossover claim when billing Medicaid for any Medicare Advantage deductible, coinsurance or copay. Follow the instructions in section 5.4 or 5.6.2.

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In addition, claims billed to and paid by Medicare for Railroad Retirees will be denied by Medicaid with denial code 2808 when the claim is crossed over from Medicare. The error message provided with denial code 2808 states "*COBA – MEDICARE ID NOT ON FILE*". Medicaid's claim system is unable to match the Medicare ID submitted on the claim by the provider to the Medicare ID provided by CMS on its Medicare enrollment database as CMS converts Railroad Retiree Medicare IDs into a different format than what is listed on a recipient's ID card. If a provider receives a denial code of 2808 on a COBA crossover claim and the recipient is a Railroad Retiree the provider should resubmit the crossover claim through the Provider web portal using the crossover claim form and the recipient's Medicaid ID number.

- *Required Attachments*, which lists and describes the Alabama Medicaid required attachments
- *Adjustments,* which provides instructions for submitting online adjustments.
- *Refunds,* which provides instructions on receiving refunds
- *Inquiring about Claim and Payment Status,* which describes various methods for contacting Gainwell to inquire about claim and payment status

5.1 Before You Submit Your Claim

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

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

5.1.1 Valid Alabama Medicaid Claim Types

Alabama Medicaid processes eight different claim types (Managed Care claims are described in Chapter 40, Alabama Coordinated Health Network (ACHN). The claims must be submitted in electronic format. Alabama recognizes two standard claim forms (UB-04 and CMS-1500) and three Medicaid non-standard claim forms (Pharmacy, Dental, and one Medicare/Medicaid-related claim form). The provider's provider type determines which claim type to bill, as illustrated in the table below.

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Claim Type	*Claim Form*	*HIPAA Transaction*	*Providers Who Bill Using This Claim Type*
Medical	CMS-1500	837 Professional	• Physicians • Physician Employed Practitioners (CRNP and PA) • Independent Labs • Independent Radiology • Transportation • Prosthetic Services • DME • Podiatrists • Chiropractors • Psychologists • Audiologists • Therapists (Physical, Speech, Occupational) • Optometrists/Opticians • Optical Dispensing Contractor • Clinics • Rural Health Clinics (IRHC, PBRHC) • FQHC • County Health Departments • Targeted Case Management • Independent Nurse Practitioner • Hearing Aid Dealer • Waiver Services (Homebound, Elderly and Disabled, MR/DD) • Maternity Care • State Rehab Services (Mental Health Centers, DYS, DHR) • CRNA • Nurse Midwife
Dental	2012 ADA	837 Dental	Dentists/Oral Surgeons when billing CDT codes
Pharmacy	XIX-BC-10-93	NCPDP	Pharmacists
Inpatient	UB-04	837 Institutional	• Hospitals • ICF/MR Facility • Nursing Facility
Outpatient	UB-04	837 Institutional	• Hospitals • Ambulatory Surgical Centers (straight Medicaid) • Hemodialysis • Private Duty Nursing • Hospice Facility • Home Health Services • Lithotripsy (ESWL)
Medical crossover	Medical Medicare/Medicaid-Related Claim	837 Professional	All providers listed under the medical claim type • Ambulatory Surgical Centers (crossover claims)

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

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

Claims Processing

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

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

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

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

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

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

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

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

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

5.1.3 Methods for Submitting Claims

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

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

NOTE:

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

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

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

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

5.1.4 Electronic Claims Submission

Electronic claims may be submitted using a variety of methods:

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

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

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

Electronic claims begin processing as soon as they are received by the system. Paper claims must go through lengthy processing procedures, which could result in delayed payment on the claims. An electronically submitted claim displays on the next Remittance Advice (RA) following the claim submission. Unless your claim suspends for medical policy reasons, it should finalize (pay or deny) in the check writing 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. Gainwell furnishes file specifications at no charge. **If you have further questions or wish to order software, contact the Gainwell Electronic Claims Submission (ECS) Help Desk at 1(800) 456-1242** (out of state providers call (334) 215-0111).

5.1.5 Filing Limits and Approved Exceptions

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

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

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

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

NOTE:

This section shall not apply to claims recouped through medical record reviews and/or investigations. Recouped claims from medical record reviews and/or investigations are considered final and are not subject to resubmission. Medical record reviews include, but are not limited to those performed by: the Medicaid Program Integrity Division, the Recovery Audit Contractor (RAC), the Medicaid Integrity Contractor (MIC) and Payment Error Rate Measurement (PERM) contractor.

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

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

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NOTE:

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

5.1.6 Recipient Signatures

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

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

NOTE:

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

5.1.7 Provider Signatures

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

Medical Claims

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

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

- Disclose the extent of services the provider furnishes to recipients

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- 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 Provider Agreement on file should place the words "**Agreement on File**" in block 31.

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

Tape Billers

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

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

Electronic Billers

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

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 Provider Agreement is on file.

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

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5.1.8 Submitting Paid and Partially Paid Claims to Medicaid

Providers may submit paid, partially paid, and deductible applied third party claims to Medicaid using the approved paper or online filing methods as described in Chapter 5, Filing Claims. Additionally, to capture third party payment information, a TPL panel (for electronic claims) or a Medicaid Other Insurance Attachment form (for paper claims) is required to provide the other payer amounts that were applied to the following: paid amount, deductible amount, coinsurance amount, and co-pay amount. Completion instructions for the TPL panel may be found in the Provider Electronic Solutions (PES) User Guide and the interactive Service-Web User Guide. Completion instructions for the Medicaid Other Insurance attachment form may be found in section 5.7 of this chapter. **The following third party-related information is also required on the claim,** in addition to the other required claim data:

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

NOTE:

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

NOTE:

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

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

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

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

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

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

5.1.9 Submitting Denied Claims to Medicaid

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

Claim Form	*Include the Following Third Party Information*	*In These Claim Fields*
CMS-1500	• Other Insured's name, policy number, insurance co. • Was condition related to (accident) • TPL denied dates	• Blocks 9-9d • Block 10 • Block 19

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

Currently, certain claims with a third party denial **may** be submitted via the Medicaid Interactive Web Portal or on paper with a copy of the third party denial attached. Effective **July 01, 2021** all claims with a third party denial on the approved list **must be submitted electronically.**

The list of denial codes that may be submitted electronically can be found here: https://medicaid.alabama.gov/content/7.0_Providers/7.1_Third_Party.aspx

Claims with a third party denial that are submitted on paper will also be reviewed against the published list of acceptable TPL denials. Other denial codes which are not on the list will require additional justification and must be submitted on a paper claim to the fiscal agent. Providers must submit justification or documentation as to why the primary payer cannot be billed or will not pay the claim in order to prove that a good faith effort has been made to obtain payment from a primary payer. Examples of acceptable documentation may include legible copies of third party denials, a brief explanation of additional submitted documentation, such as diagnosis codes to justify medical necessity, and providers do not meet certain requirements of the third party, etc. If acceptable documentation is not attached, the paper claim will be returned to the provider.

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.

Third party denials should be attached to the paper claim or they may be submitted via the Interactive Web Portal or via Fax with an Attachment Control Number (ACN) generated via the Interactive Web Portal. Claims with a third party denial that are submitted electronically must include an ACN. Review the ALERT of May 04, 2020 found here: https://medicaid.alabama.gov/alert_detail.aspx?ID=13860, for detailed instructions for the electronic process.

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Please see chapter 20, Third Party, Rule No. 560-X-20-.04 Third Party Payments/Denials, for additional information. The chapter can be found here, https://medicaid.alabama.gov/documents/9.0_Resources/9.2_Administrative_Code/9.2_Adm_Code_Chap_20_Third_Party_2-13-15.pdf.

NOTE:

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

5.2 Completing the CMS-1500 Claim Form

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

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

CMS-1500 Electronic Billing

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

Providers can obtain Provider Electronic Solutions software from Gainwell free of charge. Providers may also utilize Medicaid's Interactive Web Portal. Gainwell 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 Gainwell Electronic Claims Submission Help Desk at 1(800) 456-1242.

CMS-1500 Claims Form Paper Billing

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 CMS format using red dropout ink.

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

Critical claim information includes:

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

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- Payee's 10-digit NPI
- Rendering (performing) provider's 10-digit NPI (on each line item)

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

Guidance Regarding NDC's on the CMS-1500 Form

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

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

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

  Result: 0xxxxxxxxxx.

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

  Result: xxxxx0xxxxx.

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

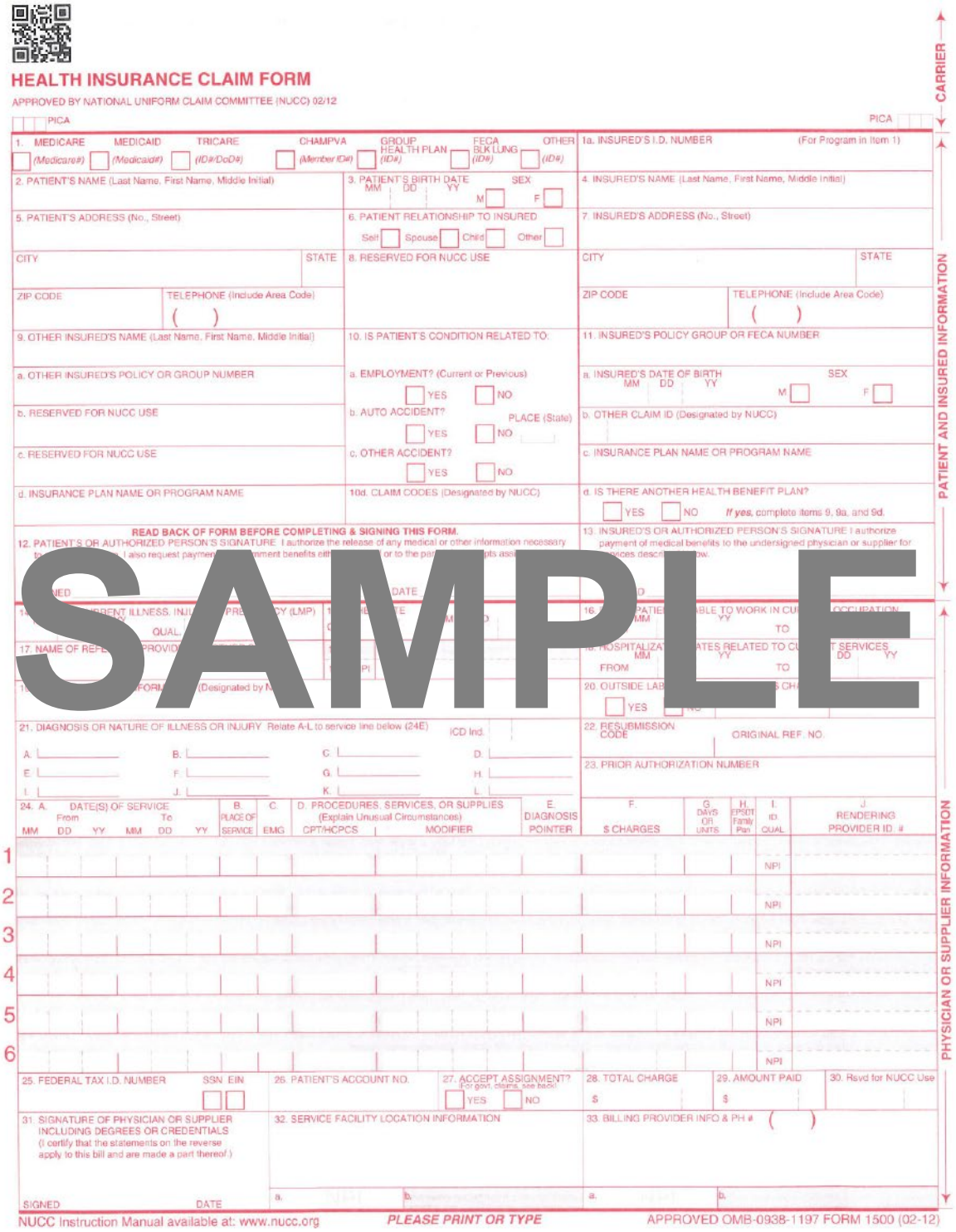
  Result: xxxxxxxxx0x.

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

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

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5.2.1 CMS-1500 Blank Claim Form



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

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

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

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

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

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

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

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

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

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

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) YES NO

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

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

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 ... I also request payment ... or to the pa... pts ass...

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for ... ices desc... low.

...ED DATE ...D

...PRENT ILLNESS, INJU... PRE... Y (LMP) ... TE ... MM ... D ... 16. ...PATIE... ...BLE TO WORK IN CU... MM ... YY ... OCCUPATION

QUAL. TO

17. NAME OF REFE... PROVID... ...PI ... HOSPITALIZA... MM ... YY ...ATES RELATED TO CU... ...T SERVICES MM DD YY

FROM TO

... FORM ... (Designated by N...

20. OUTSIDE LAB ... YES ... NO ... $ CHA...

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

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

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

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

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

a. b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

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5.2.2 CMS-1500 Claim Filing Instructions

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

Block No.	*Description*	*Guidelines*
1a	Insured's ID Number	Enter the patient's 13-digit recipient number (12 digits plus the check digit) from the Medicaid identification card and/or eligibility verification response. Effective January 17, 2011, the Alabama Medicaid Agency is phasing out the acceptance of the old Medicaid ID Number (number beginning with '000"). Only the new Medicaid ID number (number beginning with a "5") will be accepted for claims processing purposes for claims received on or after January 17, 2011. **For instructions on performing an eligibility verification transaction, please refer to Chapter 3, Verifying Recipient Eligibility.**
2	Patient's name	Enter the recipient's name **exactly** as it is given to you as a result of the eligibility verification transaction. **Please note that the recipient name on the claim form must match the name on file for the RID number you entered in Block 1.** If a recipient has two initials instead of a first name, enter the first initial along with a long space, then the second initial and no periods. If a recipient's first name contains an apostrophe, enter the first name including the apostrophe. **Examples:** For recipient A. B. Doe, enter "Doe A B" with no punctuation. For recipient D'Andre Doe, enter "Doe D'Andre" with an apostrophe and no spaces.
3	Patient's date of birth Patient's sex	Enter the month, day, and year (MM/DD/YY) the recipient was born. Indicate the recipient's sex by checking the appropriate box.
5	Patient's address	Enter the patient's complete address as described (city, state, and ZIP code).
9	Other insured's name (Last name, first name and middle initial)	Enter all pertinent information (9, 9a and 9d) if the recipient has other health insurance coverage. **Providers must submit the claim to other insurers prior to submitting the claim to Medicaid.**
9a	Other Insured's Policy or Group Number	Enter the Recipient's other insurance policy or group Number.
9d	Insurance Plan or Program Name	Name of insurance plan or program.
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."

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Block No.	*Description*	*Guidelines*
10d	Claim Codes	Enter the appropriate condition code allowed by NUCC. - Valid values include: AA – Abortion performed due to rape AB – Abortion performed due to incest AC – Abortion performed due to serious fetal genetic defect, deformity, or abnormality AD – Abortion performed due to life endangering physical condition caused by, rising from or exacerbated by the pregnancy Itself AE – Abortion performed due to physical health of mother that is not life endangering AF – Abortion performed due to emotional/psychological health of mother AG – Abortion performed due to social or economic Reasons AH – Elective Abortion AI - Sterilization
14	Date of Current Illness, Injury, or Pregnancy	Enter the applicable qualifier to identify which date is being reported: 431 - Onset of Current Symptoms or Illness 484 - Last Menstrual Period This field allows for the entry of the following: 2 digits under MM, 2 digits under DD, 4 digits under YY, and 3 characters to the right of the vertical, dotted line.
15	Other Date	Enter the applicable qualifier to identify which date is being reported: 090 - Report Start (Assumed Care Date) 091 - Report End (Relinquished Care Date) 304 - Latest Visit or Consultation 439 - Accident 444 - First Visit or Consultation 453 - Acute Manifestation of a Chronic Condition 454 - Initial Treatment 455 - Last X-ray 471 - Prescription This field allows for the entry of the following: 3 characters between the vertical, dotted lines, 2 digits under MM, 2 digits under DD, and 4 digits under YY.
17	Name of referring physician or other source	Enter one of the following, if applicable: • The name of the referring ACHN (for maternity services) • 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	Secondary ID	Enter the secondary identifier for the referring provider in this field. The secondary identifier should be the legacy Medicaid provider number of the provider which rendered the service. **This is an optional field, but is required for providers with multiple service locations.**

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Block No.	*Description*	*Guidelines*
17B	Referring NPI number	A referring NPI should only be included for lock-in, EPSDT or Delivering Healthcare Professionals (DHCP).
19	Additional Claim Information	Identifies additional information about the patient's condition on the claim. Use this block to provide remarks, as appropriate. Examples include, but are not limited to the following: • TPL paid (MM/DD/YY) • TPL denied (MM/DD/YY) • Recouped claim (MM/DD/YY) The substitute provider's name may also be indicated here.
21	Diagnosis or nature of illness or injury and ICD Ind.	A. - L. 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. Enter ICD indicator for diagnosis codes entered in fields 21A – 21L. • Enter "9" for ICD-9 • Enter "0" for ICD-10 May not submit both ICD versions together on the same claim. **Providers should not submit ICD-10 codes until CMS mandate date.**
23	Prior Authorization Number	For prior authorization requests approved by Medicaid, the prior authorization number will be automatically entered into the claims system by Medicaid's contractor. For general information regarding prior authorization, refer to Chapter 4, Obtaining Prior Authorization. For program-specific prior authorization information, refer to the chapter in Part II that corresponds to your provider or program type. **Do not use for any other number. Leave blank if this does not apply.**
24a	Date of service (DOS)	Enter the date of service for each procedure provided in a MM/DD/YY format. If identical services (and charges) are performed on the same day, enter the same date of service in both "from" and "to" spaces, and enter the units perform in Block 24g. **Exception**: Provider visits to residents in nursing facilities must be billed showing one visit per line. If entering NDC information, enter N4 qualifier in the first two positions, left justified, followed immediately by the 11 character NDC number (no hyphens).
24b	Place of service (POS)	Enter a valid place of service (POS) code for each procedure. For program-specific POS values, refer to the chapter in Part II that corresponds to your provider or program type.
24c	EMG	This field is used to indicate certain co-payment exemptions: • Enter an "A" for Native American Indian with an active user letter • Enter an "E" for certified emergency • Enter a "P" for pregnancy Do not enter Y or N.

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Block No.	*Description*	*Guidelines*
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. Note: Up to 4 modifiers can be entered per procedure code.
24e	Diagnosis Pointer	Enter the line item reference (A - L) for each service or procedure as it relates to the primary ICD-9 or ICD-10 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. Up to 4 characters can be entered in this block per procedure code
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	Days or Units	Enter the appropriate number of units. Be sure that span-billed visits equal the units in this block. Use whole numbers only.
24h	EPSDT Family 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 • "4" if the procedure is EPSDT
24I	ID Qual	Enter in the shaded area of 24I the qualifier identifying if the number is a non-NPI. This will only be used for providers that are not required to obtain an NPI. These providers should use the following identifier in 24I: ID which identifies the number being used as a Medicaid provider number. Should a provider need to use a taxonomy code on a claim, use the following: ZZ which identifies the number being used is a provider taxonomy code.
24J	Rendering provider ID	The individual provider performing the service is reported in 24J. If not entering an NPI, the number should appear in the shaded area of the field. The NPI number should be entered in the non-shaded area. Secondary ID: Enter the secondary identifier for the performing provider in the shaded area of the field. The secondary identifier should be the legacy Medicaid provider number of provider which rendered the service. This is an optional field, but is required for providers with multiple service locations.
26	Patient account number	This field is optional. Up to 20 alphanumeric characters may be entered in this field. If entered, the number appears on the provider's Remittance Advice (RA) to assist in patient identification.
28	Total charge	Enter the sum of all charges entered in Block 24f lines 1-6.
31	Signature of physician or supplier	After reading the provider certification on the back of the claim form, sign the claim. In lieu of signing the claim form, a signed Provider Agreement, must be on file with Gainwell. 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.

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Block No.	*Description*	*Guidelines*
32	Service Facility Location Information	Enter the performing providers name, street address, city, state, zip code, and tax ID.
32a	Rendering Provider NPI	Enter the NPI for the rendering provider performing the service.
32b	Rendering Provider Medicaid ID	Enter the Medicaid ID for the rendering provider performing the service.
33	Billing Provider Info and Phone Number	1st Line: Name of the Payee provider as it appears in the Gainwell system 2nd Line: Address 3rd Line: City, State and Zip Code (include zip+4) 33A: Enter the payee (group) NPI 33B: Enter the two-digit qualifier (G2) identifying the non-NPI number followed by the ID number. Do not enter a space, hyphen or other separator between the qualifier and the number. (Only for providers who do not qualify to receive an NPI).

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5.3 Completing the UB-04 Claim Form

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

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

UB-04 Electronic Billing

Electronic billers must submit UB-04/837 Institutional claims in approved formats. The 837 Institutional transaction allows providers to bill up to 999 details per Institutional (837 Institutional transaction) claim type. Providers can obtain Provider Electronic Solutions software from Gainwell free of charge. Gainwell 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 Gainwell Electronic Claims Submission Help Desk at 1(800) 456-1242.

UB-04 Claims Form Paper Billing

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

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

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

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

NOTE:

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

Guidance Regarding NDC's on the UB-04 Form

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

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manufacturer of the drug. The next 4-digits identify the specific strength, dosage form, and formulation of that drug. The last 2-digits identify the package size of the drug.

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

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

  Result: 0xxxxxxxxxx.

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

  Result: xxxxx0xxxxx.

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

  Result: xxxxxxxxx0x.

Please refer to the Food and Drug Administration (FDA) website below for more information regarding the National Drug Code, https://www.accessdata.fda.gov/scripts/cder/daf/index.cfm.

For additional questions regarding the CMS list of Top 20 physician administered drugs, please contact Pharmacy Services at (334) 242-5050.

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5.3.1 UB-04 Blank Claim Form



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5.3.2 UB-04 Claim Filing Instructions

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

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Block No.	Description	Guidelines
1	Provider name, address, and telephone number	Enter the provider name, street address, city, state, ZIP code, and telephone number of the service location.
2	Pay to name/address	Required when the pay-to name and address information is different from the billing information in block 1. If used, providers must include, name, address, city, state, and zip.
3A 3B	Patient control number	**Optional**: Enter patient's unique number assigned by the provider to facilitate retrieval of individual's account of services containing the financial billing records. **3B**: Enter the patient's medical record number assigned to the hospital. This number will be referenced on the provider's Remittance Advice for patient identification. Up to twenty-four numeric characters may be entered in this field. .
4	Type of bill (TOB) Most commonly used: 111 Inpatient hospital 131 Outpatient hospital 141 Non-patient (laboratory or radiology charges) 211 Long Term Care 331 Home health agency 811 Hospice 831 Ambulatory Surgical Center	Enter the four-digit type of bill (TOB) code: **1st Digit – Type of Facility** 1 Hospital 2 Long Term Care 3 Home Health Agency 7 Clinic (RHC, FQHC) *** see note** 8 Special Facility **** see note** **2nd Digit – Bill Classification** 1 Inpatient (including Medicare Part A) 2 Inpatient (Medicare Part B only) 3 Outpatient 4 Other (for hospital-reference diagnostic services; for example, laboratories and x-rays) **3rd Digit – Frequency** 0 Nonpayment/zero claim 1 Admit through discharge 2 Interim – first claim 3 Interim – continuing claim 4 Interim – last claim 5 Late charge(s) only claim ***Clinic requires one of the following as the 2nd Digit – Bill Classification:** 1 Rural Health 2 Hospital-Based or Independent Renal Dialysis Center 3 Free-Standing 4 Outpatient Rehabilitation Facility (ORF) 5 Comprehensive Outpatient Rehabilitation Facility (CORF) 6-8 Reserved for National Assignment 9 Other ****Special Facility requires one of the following as the 2nd Digit – Bill Classification:** 1 Hospice (non-hospital-based) 2 Hospice (hospital-based) 3 Ambulatory Surgical Center 4 Free-Standing Birthing Center 5 Critical Access Hospital 6 Residential Facility 7-8 Reserved for national assignment 9 Other

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

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Block No.	Description	Guidelines
16	Discharge hour	For inpatient claims, enter the hour of discharge or death. Use military time (00 to 23) to express the hour of discharge. If this is an interim bill (patient status of "30"), leave the block blank. Code 99 is not acceptable.
17	Patient discharge status	For inpatient claims, enter the appropriate two-digit code to indicate the patient's status as of the statement "through" date. Refer to the UB-04 Billing Manual for the valid patient status codes. If status code 30, the total days in blocks 7 and 8 should include all days listed in the statement covers period. If any other status code is used, do not count the last date of service (discharge date).
18-28	Condition Codes	Used to indicate EPSDT-Referrals, Family Planning Services, and Co-payment exemptions. A1 Denotes services rendered as the result of an EPSDT screening. Block 78 must also contain the screening 10-digit NPI number. A4 Denotes services rendered as the result of family planning and will exempt the claim from copay. AJ Denotes services rendered for Native American Indian with an active user letter and will exempt the claim from copay.
29	Accident State	REQUIRED ONLY IF AUTO ACCIDENT: Indicate two-digit state abbreviation where the accident occurred.
31-34	Occurrence Codes	Accident related occurrence codes are required for the following diagnosis codes ICD-9 80000-9949 ICD-10 D7801 - D7889 N9989 - N9989 E3601 - E368 R6510 - R6520 E89810 - E8989 S0000XA - T3499XS G038 - G038 T378X1A - T378X1S G970 - G970 T38891A - T38891S G972 - G9732 T410X1A - T410X1S G9748 - G9782 T451X1A - T451X1S H59011 - H59329 T458X1A - T458X1S H59811 - H5989 T46991A - T46991S H9521 - H9589 T481X1A - T481X1S I973 - I9789 T502X1A - T502X1S J954 - J9572 T50991A - T50991S J95830 - J95831 T50995A - T50995S J95851 - J9589 T50A91A - T50A92S K6811 - K6811 T50B91A - T50B91S K913 - K913 T50Z91A - T50Z91S K9161 - K91841 T510X1A - T5994XS

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Block No.	Description	Guidelines
		K9186 - K9189 L7601 - L7682 M1A10X0 - M1A19X1 M4840XD - M4858XS M8000XA - M8088XS M8430XA - M8468XS M96621 - M9689 M9910 - M9919 N980 - N990 N99520 - N99821 T602X2A - T602X2S T6101XA - T6294XS T650X1A - T651X4S T653X1A - T654X4S T65894A - T65894S T66XXXA - T71154S T71191A - T886XXD T887XXA - T887XXD T888XXA - T889XXS
39-41	Value Codes and Amounts	Enter the appropriate value code and amount according to the following: 73 Denotes the Medicare Paid Amount 74 Denotes the Medicare Allowed Amount 75 Denotes the Sequestration Reduction 80 Denotes the Covered Days 81 Denotes the Non-Covered Days 82 Denotes the Co-Insurance Days 83 Lifetime Reserve Days A1 Denotes the Medicare Deductible Amount A2 Denotes the Medicare Co-Insurance Amount A7 Medicare Copay
42, 43	Revenue codes, revenue description	Enter the revenue code(s) for the services billed. Revenue 001 (total) must appear on each claim. If entering NDC information, enter N4 qualifier in the first two positions, left justified, followed immediately by the 11 character NDC number (no hyphens).
44	HCPCS/Rates	Inpatient: Enter the accommodation rate per day. Home Health: Home Health agencies must have the appropriate HCPCS procedure code. Outpatient: Outpatient claims must have the appropriate HCPCS, procedure code, and NDC. The UB-04 claim form is limited to 23 detail charges.
45	Service date	Outpatient: Enter the date of service that the outpatient procedure was performed. Nursing Homes: Enter the beginning date of service for the revenue code being billed. Span Billing: When filing for services such as therapies, home health visits, dialysis, hospice, and private duty nursing within a month, the time period being billed should be entered in form locator (FL) 6 (statement covers period). In FL 45, the service date should be the first date in the statement covers period. The number of units should match the number of services reflected in the medical record.

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Block No.	Description	Guidelines
46	Units of service	Enter total number of units of service for outpatient and inpatient services. For inpatient claims, this will be same as covered plus non-covered days.
47	Total charges	Enter the total charges for each service provided.
48	Non-covered charges	Enter the portion of the total that is non-covered for each line item.
50	Payer	Enter the name identifying each payer organization from which the provider might accept some payment for the charges.
56	NPI Number	Enter the 10- digit NPI Number
58	Insured's name	Enter the insured's name.
60	Insurance identification number	Enter the patient's 13-digit RID from the Medicaid eligibility verification response and the policy numbers for any other insurance on file. Effective January 17, 2011, the Alabama Medicaid Agency is phasing out the acceptance of the old Medicaid ID Number (number beginning with '000"). Only the new Medicaid ID number (number beginning with a "5") will be accepted for claims processing purposes for claims received on or after January 17, 2011.
61	Insured group's name	Enter the name of the group or plan through which the insurance is provided to the insured.
62	Insurance group number	Enter the group number of the other health insurance.
66	ICD Version Indicator	The qualifier denotes the version of the ICD reported. 9=Ninth Revision 0=Tenth Revision.
67	Principal diagnosis code Present on admission indicator	Enter the ICD-9 or ICD-10 diagnosis code for the principal diagnosis to the highest number of digits possible (3, 4, or 5). Do not use decimal points in the diagnosis code field. Enter the present on admission (POA) indicator in shaded part of the field. This indicator is required for certain diagnosis codes and only on inpatient claims. Valid values are: Y – Diagnosis was present at time of inpatient admission. N – Diagnosis was not present at the time of inpatient admission. U – Documentation insufficient to determine if condition was present at the time of inpatient admission. W – Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time if inpatient admission.
67A-67Q	Other diagnosis codes Present on admission indicator	Enter the ICD-9 or ICD-10 diagnosis code to the highest number of digits possible (3, 4, or 5) for each additional diagnosis. Do not use decimal points in the diagnosis code field. Enter one diagnosis per block. Enter the present on admission (POA) indicator in the shaded part of the field. This indicator is required for certain diagnosis codes and only on inpatient claims.
69	Admitting diagnosis	**For Inpatient Claims**: Enter the admitting ICD-9 or ICD-10 diagnosis code to the highest number of digits possible (3, 4, or 5). Do not use decimal points in the diagnosis code field.

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Block No.	Description	Guidelines
70	Patient Reason DX	**For Outpatient claims only**- Enter the diagnosis for reason the recipient came in for treatment. Up to 3 patient reason diagnosis codes may be entered into this field. **NOTE**: This diagnosis is not always the same as the primary diagnosis.
73	Medicaid emergency/accident indicator	Enter an "H" to indicate that the service was rendered as a result of a home accident or treatment due to disease. Enter an "E" to indicate a certified emergency. A certified emergency ER claim must be certified by the attending licensed physician, nurse practitioner or provider assistant. Both values may be entered, as applicable.
74a-74e	Principal and other procedure codes and dates	For inpatient hospital claims only, enter the ICD-9 or ICD-10 procedure code for each surgical procedure and the date performed. Up to 5 surgical procedure codes and dates may be entered into this field.
76	Attending Physician ID	Enter the attending physician's NPI number and the appropriate qualifier "0B" followed by the physician's license number. Refer to the Alabama Medicaid Agency Provider License Book for a complete listing of valid license numbers.
77	Operating physician ID	For inpatient hospital claims only, if surgical procedure codes are entered in Block 74, enter the surgeon's NPI number and the appropriate qualifier "0B" followed by the surgeon's license number.
78	Other physician ID	Used to enter the other physician, assisting physician, referring physician or ordering provider ID. Enter the referring physician's NPI number followed by the appropriate qualifier "DN" for the following types of referrals: • EPSDT referrals • DHCP referrals • Lock-in Physician referrals If not applicable, leave blank
80	Remarks	Use this block to provide remarks, as appropriate. Examples include, but are not limited to the following: • TPL paid (MM/DD/YY) • TPL denied (MM/DD/YY) • Retroactive eligibility award date

NOTE:

When a recipient is enrolled in a Medicare Advantage Plan and Medicaid has not paid a monthly capitation payment, institutional providers must use the UB-04 claim form when billing Medicaid for Medicare Advantage plan deductibles, coinsurances, or co-pays. These claims will be processed by Medicaid in the same manner as a Medicare paid claim. Report Medicare Advantage deductibles, coinsurances, and co-pays using the appropriate Medicare value code listed in the instructions for fields 39-41 of this section.

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5.4 Completing the ADA Dental Form

Effective June 1, 2017, use the 2012 ADA Dental Claim Form. Through May 31, 2017, use the 2006 ADA Dental Claim Form.

This section describes how to complete the 2012 ADA Dental form for submission to Gainwell. For a list of providers who bill for services using the ADA Dental form, please refer to Section 5.1.1, Valid Alabama Medicaid Claim Types.

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

Effective June 1, 2017, only version 2012 ADA Dental form is acceptable. If you experience problems with Gainwell processing your forms, contact Gainwell for resolution.

ADA Dental Electronic Billing

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

Providers can obtain Provider Electronic Solutions software from Gainwell free of charge. Providers may also use Medicaid's Interactive Web Portal. Gainwell 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 Gainwell Electronic Claims Submission Help Desk at 1(800) 456-1242.

ADA Dental Claim Form Paper Billing

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

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

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

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

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NOTE:

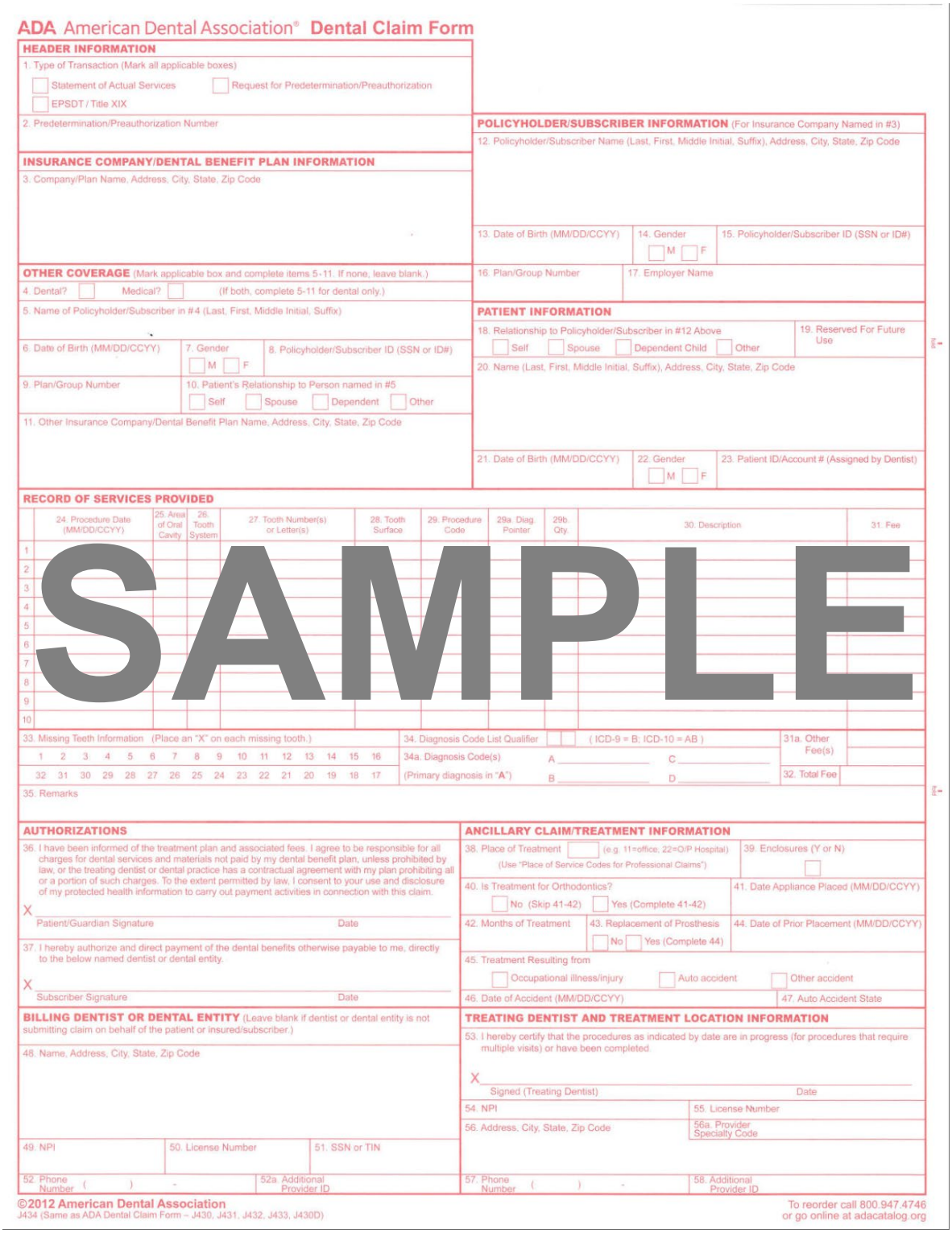
Because Gainwell uses a new scanning process, **do not use a blue pen to complete paper claims.** Do not circle, underline, write notes or highlight any information on the claim. **Send original claim forms only;** do not send copies.

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

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

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5.4.1 ADA Dental Blank Claim Form



ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

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

2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

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

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? ☐ Medical? ☐ (If both, complete 5-11 for dental only.)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY) | 7. Gender ☐ M ☐ F | 8. Policyholder/Subscriber ID (SSN or ID#)

9. Plan/Group Number | 10. Patient's Relationship to Person named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

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

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/CCYY) | 14. Gender ☐ M ☐ F | 15. Policyholder/Subscriber ID (SSN or ID#)

16. Plan/Group Number | 17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other | 19. Reserved For Future Use

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY) | 22. Gender ☐ M ☐ F | 23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

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

SAMPLE

33. Missing Teeth Information (Place an "X" on each missing tooth.)
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

34. Diagnosis Code List Qualifier ☐☐ (ICD-9 = B; ICD-10 = AB)
34a. Diagnosis Code(s) A _____ C _____
(Primary diagnosis in "A") B _____ D _____

31a. Other Fee(s)
32. Total Fee

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.
X _____ Patient/Guardian Signature Date

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

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment ☐ (e.g. 11=office, 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims") | 39. Enclosures (Y or N) ☐

40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42) | 41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment | 43. Replacement of Prosthesis ☐ No ☐ Yes (Complete 44) | 44. Date of Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY) | 47. Auto Accident State

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

48. Name, Address, City, State, Zip Code

49. NPI | 50. License Number | 51. SSN or TIN

52. Phone Number ( ) - | 52a. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

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

54. NPI | 55. License Number

56. Address, City, State, Zip Code | 56a. Provider Specialty Code

57. Phone Number ( ) - | 58. Additional Provider ID

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J434 (Same as ADA Dental Claim Form – J430, J431, J432, J433, J430D)

To reorder call 800.947.4746 or go online at adacatalog.org

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5.4.2 ADA Dental Filing Instructions

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

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

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ADA Block No.	***ADA Description Alabama Medicaid Use***	***Guidelines***
25	Area of the Oral Cavity	If applicable, enter the Oral Cavity Designation Code associated with the procedure being performed on a specific tooth. 00 —Full Mouth 01 —Upper Arch 02 —Lower Arch 09 —Other Area of Oral Cavity 10 —Upper Right Quadrant 20 —Upper Left Quadrant 30 —Lower Left Quadrant 40 —Lower Right Quadrant L —Left R—Right There are few procedures that require an oral cavity designation code. Some of these include but are not limited to D4341, D4355, D4910, D7970 and D7971.
27	Tooth Number(s) or Letter(s)	Enter the appropriate tooth number for the permanent teeth (01-32) or the appropriate letter for primary teeth (A-T) as indicated on the claim form. Enter AS – TS for children and 51-82 for adults with supernumerary teeth regardless of location in maxilla or mandible. Permanent teeth must be two-digit fields. For tooth number 1-9, you must indicate 01-09.
28	Tooth Surface	Enter the appropriate tooth surface alpha character of the tooth on which the service is performed (BDM, MOB, MODL, MODBL). The block is left blank for exams, X-rays, fluoride and crowns. M – Mesial F – Facial; Labial O – Occlusal L – Lingual or Cingulum D – Distal I – Incisal B —Buccal; Labial
29	Procedure Code	Enter the appropriate ADA procedure code(s) for the procedure.
29a	Diagnosis Pointer	Enter appropriate diagnosis listed in section 34a.
31	Fee	Enter the usual and customary charges for each line of service listed. Charges must not be higher than the fees charged to private pay patients.
34	Diagnosis Code List Qualifier	Enter AB for ICD-10 diagnosis Enter B for ICD-9 diagnosis.
34a	Diagnosis Code(s)	Enter Primary diagnosis on line A. You may enter a maximum of 4 diagnosis.
35	Remarks	The only information that should be written in this section is “TPL Denial Attached” and the date of the third party denial (other insurance) Make sure the EOB denial statement is attached. NO OTHER comments should be written in this section.

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ADA Block No.	*ADA Description Alabama Medicaid Use*	*Guidelines*
38	Place of Treatment	Check applicable box. ***Use the Hospital box to indicate outpatient hospital or inpatient hospital.
45	Treatment Resulting From	If applicable, check only one box: Occupational illness/injury Auto accident Other accident
46	Date of Accident	Enter numerically (MM/DD/CCYY) the date of the accident.
47	Auto Accident State	Enter the two-digit state abbreviation of the state in which the accident happened.
48	Billing Dentist or Dental Entity (Name, Address, City, State, Zip Code)	Enter the billing provider's name, street address, city, state, and zip code.
49	NPI	Enter the Organizational/**Billing** NPI number.
52A	Additional Provider ID	Enter the **billing** provider's Alabama Medicaid provider number.
53	Treating Dentist and Treatment Location Information [provider's signature]	Each claim form must have a provider signature, initials by a stamped signature, or an agreement on file with Gainwell to omit signature requirement. Refer to the Alabama Medicaid Provider Manual, Chapter 5 section 5.1.7, Provider Signatures, for appropriate signature requirements.
54	NPI	Enter the NPI of the dentist performing the service, i.e. the **treating** (rendering or performing) dentist's NPI number.
56A	Provider Specialty Code	Optional: Enter the taxonomy code of the **treating** (rendering or performing) dentist.
58	Additional Provider ID	Enter the **treating** (rendering or performing) provider's Alabama Medicaid provider number.

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5.5 Completing the Pharmacy Claim Form

This section describes how to complete the pharmacy claim form for submission to Gainwell. 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 Gainwell free of charge. Providers may also use Medicaid's Interactive Web Portal. Gainwell 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 Gainwell Electronic Claims Submission Help Desk at 1(800) 456-1242.

Pharmacy Paper Billing

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

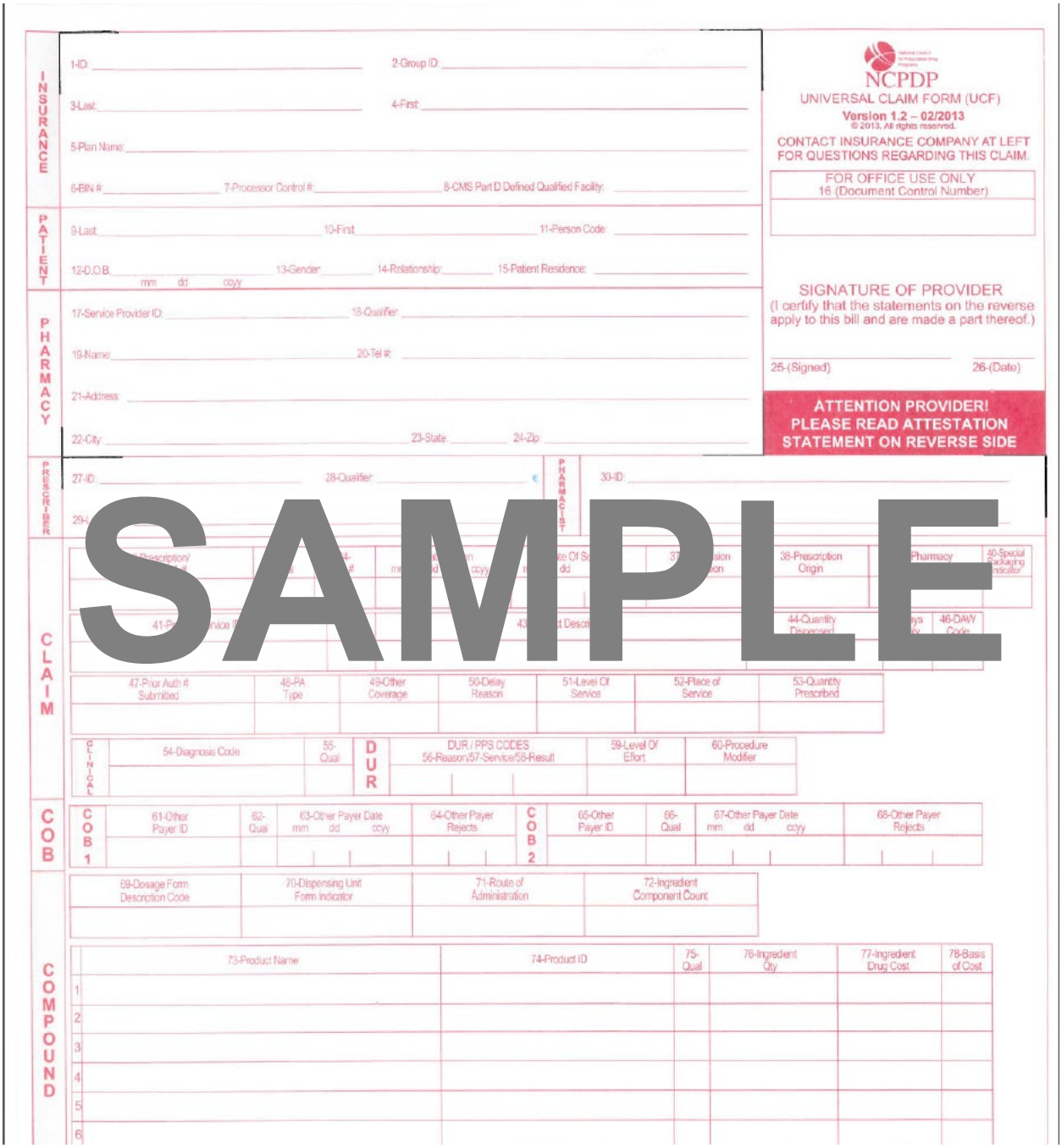
Claims must contain the billing provider's complete name, address, and NPI. **Critical claim information includes:**

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

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

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5.5.1 Pharmacy Blank Claim Form



SAMPLE

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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 Gainwell.**

Block Number	***Field Description***	***Guidelines***
1	Recipient name and Medicaid number	Enter the recipient's 13-digit RID number. Effective January 17, 2011, the Alabama Medicaid Agency is phasing out the acceptance of the old Medicaid ID Number (number beginning with '000"). Only the new Medicaid ID number (number beginning with a "5") will be accepted for claims processing purposes for claims received on or after January 17, 2011.
2	Group ID	Not Used.
3	Last Name of Cardholders	Enter the Last Name.
4	First Name of Cardholder	Enter the First Name.
5	Plan Name	Not Used.
6	BIN Number	Alabama Value=ØØ4146
7	Processor Control Number	Not Used.
8	CMS Part D Defined Qualified Facility	Y = Yes=CMS qualified facility N = No=Not a CMS qualified facility
9	Recipient Last Name	Enter the Recipient's last 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 the Medicaid Number block.**
10	Recipient First Name	Enter the recipient's first name. 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.
11	Person Code	Not Used.
12	Recipient Date of Birth	Enter date of birth of recipient. MMDDCCYY.
13	Recipient Gender	Enter Recipient Gender. 0 – Not Specified 1 – Male 2 - Female
14	Relationship	Enter recipient relationship to the Cardholder. 0 – Not Specified 1 – Cardholder 2 – Spouse 3 – Child 4 - Other

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Block Number	*Field Description*	*Guidelines*
15	Patient Residence	Enter recipient residence. Ø = Not Specified. 1 = Home 2 = Skilled Nursing Facility 3 = Nursing Facility. 4 = Assisted Living Facility 5 = Custodial Care Facility 6 = Group Home 7 = Inpatient Psychiatric Facility 8 = Psychiatric Facility – Partial Hospitalization 9 = Intermediate Care Facility/Mentally Retarded 1Ø = Residential Substance Abuse Treatment Facility 11 = Hospice 12 = Psychiatric Residential Treatment Facility 13 = Comprehensive Inpatient Rehabilitation Facility 14 = Homeless Shelter 15 = Correctional Institution
16	Document Control Number	Not Used.
17	Service Provider ID	Enter the 10 digit NPI of the service provider.
18	Qualifier	Enter 01 for NPI.
19	Name of Pharmacy	Enter name of pharmacy.
20	Telephone	Not Used.
21	Pharmacy address	Enter the pharmacy street address.
22	Pharmacy address	Enter the city of pharmacy.
23	Pharmacy address	Enter the state of pharmacy.
24	Pharmacy address	Enter the zip code of pharmacy.
25	Pharmacist Signature	An authorized representative must sign his or her name or initial his or her computer-generated, stamped, or typed name.
26	Date	Enter date that the pharmacist signed.
27	Prescriber ID	Enter prescriber ID.
28	Prescriber ID Qualifier	Enter prescriber ID qualifier. 01 – NPI 08 – State License CMS
29	Prescriber Last Name	Enter prescriber last name.
30	Provider ID (Pharmacist)	Enter unique ID for person dispensing of the prescription.
31	Provider ID Qualifier (Pharmacist)	Enter the Provider ID Qualifier. 01 – DEA 02 – State License 03 – Social Security Number 04 – Name 05 – NPI 06 – HIN 07 – State Issued 99 - Other
32	Prescription Service Reference Number	Enter the twelve digit numeric prescription number.
33	Prescription/Service Reference Number Qualifier	Enter Prescription Qualifier. 1 – Rx Billing 2 – Service Billing

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Block Number	*Field Description*	*Guidelines*
34	Refills	Enter the number of refills authorized by the prescribing physician. Values can be 0-11 for non-controlled drugs, 0-5 for Class III-V narcotics, or 0 for Class II narcotics. Alabama Medicaid will not recognize values greater than 11.
35	Date Written	Enter the date the prescription was written in the format MMDDCCYY.
36	Date of Service	Enter the date the prescription was dispense in the format MMDDCCYY.
37	Submission Clarification	Enter the submission clarification code. 1 – No Override 2 – Other Override 3 – Vacation Supply 4 – Lost Prescription 5 – Therapy Change 6 – Starter Dose 7 – Medically Necessary 8 – Process Compound for Approved Ingredients 9 – Encounters 10 – Meets Plan Limitations 11- Certification on File 12 – DME Replacement Indicator 13- Payer- Recognized Emergency/Disaster Assistance Request 14 – Long Term Care Leave of Absence 15 – Long Term Care Replacement Medication 16 – Long Term Care Emergency Box or Automated Dispensing Machine 17 – Long Term Care Emergency Supply Remainder 18 – Long Term Care Patient Admit/Readmit Indicator 19 – Split Billing 99 - Other
38	Prescription Origin	Enter the origin of prescription. 0 – Not Known 1 – Written 2 – Telephone 3 – Electronic 4 – Facsimile 5 - Pharmacy
39	Pharmacy Service Type	Enter Pharmacy service type. 1 - Community/Retail Pharmacy Services 2 - Compounding Pharmacy Services 3 - Home Infusion Therapy Provider Services 4 = Institutional Pharmacy Services 5 = Long Term Care Pharmacy Services 6 = Mail Order Pharmacy Services 7 = Managed Care Organization Pharmacy Services 8 = Specialty Care Pharmacy Services 99 = Other

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Block Number	*Field Description*	*Guidelines*
40	Special Packaging Indicator	Enter special packaging indicator for type of dispensing does. 1 – Not Unit Dose 2 – Manufacturer Unit Dose 3 – Pharmacy Unit Dose 4 – Pharmacy Unit Dose Patient Compliance Packaging 5 – Pharmacy Multi-drug Patient Compliance Packaging 6 – Remote Device Unit Dose 7 – Remote Device Multi-drug Compliance 8 – Manufacturer Unit of Use Package (not unit dose)
41	Product/Service ID	Enter the 11-digit national drug code for the drug dispensed (If fields 41-44 contain data fields 73 – 78 should be blank).
42	Product/Service ID Qualifier	Enter Product/Service ID Qualifier 03 – NDC
43	Product Description	Enter the description of the product.
44	Quantity Dispensed	Enter the quantity or number of units dispensed. There are three dispensing units: • Each (ea): tablets, capsules, suppositories, patches, and insulin syringes. For example, one package of Loestrin should be coded on the claim form as 00021. • Milliliter (ml): Most suspensions and liquids will be billed per milliliter. Most injectables that are supplied in solution are also billed per milliliter. For example, a 5ml of ophthalmic solution should be coded 00005. • Gram (gm): Most creams, ointments, and powders will be billed per gram. For example, a 45gm tube of ointment should be coded as 00045. **If a product is supplied in fractional units (for instance, a 3.5gm tube of ointment), Medicaid providers should submit claims involving decimal package sizes for the exact amount being dispensed. In this example, the quantity billed should be 0003.5**
45	Days' supply	Enter the amount of time the medication dispensed should last.

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

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Block Number	*Field Description*	*Guidelines*
		manner specified by prevailing law, that generic is permitted, but the plan's formulary requests the brand product to be dispensed. **Note: These "Dispense as Written" values are required for the DAW field for electronic pharmacy claims. For more information on DAW, please visit Chapter 27 of the Billing Manual.**
47	Prior Authorization Number Submitted	Enter the prior authorization number.
48	Prior Authorization Type	Enter the prior authorization type. 0 - Not Specified 1 - Prior Authorization 2 - Medical Certification 3 - EPSDT (Early Periodic Screening Diagnosis Treatment) 4 - Exemption from Copay and/or Coinsurance 5 - Exemption from RX 6 - Family Planning Indicator 7 - TANF (Temporary Assistance for Needy Families) 8 - Payer Defined Exemption 9 - Emergency Preparedness
49	Other Coverage Code	Enter the other coverage code to indicate if patient has other insurance coverage. Blank = Not Specified 01 - Primary - First 02 - Secondary - Second 03 - Tertiary - Third 04 - Quaternary - Fourth 05 - Quinary - Fifth 06 - Senary - Sixth 07- Septenary - Seventh 08 - Octonary - Eighth 09 - Nonary - Ninth
50	Delay Reason Code	Enter specify delay reason code for the reason the transactions has been delayed. 1 - Proof of eligibility unknown or unavailable 2 - Litigation 3 - Authorization delays 4 - Delay in certifying provider 5 - Delay in supplying billing forms 6 - Delay in delivery of custom-made appliances 7 - Third party processing delay 8 - Delay in eligibility determination 9 - Original claims rejected or denied due to a reason unrelated to the billing limitation rules 10 - Administration delay in the prior approval process 11 - Other 12 - Received late with no exceptions 13 - Substantial damage by fire, etc. to provide records 14 - Theft, sabotage/other willful acts by employee
51	Level of Service	Enter the specify code for the level of services the provider rendered. 0 - Not Specified 1 - Patient consultation 2 - Home delivery 3 - Emergency 4 - 24 hour service 5 - Patient consultation regarding generic product selection 6 - In-Home Service
52	Place of Service	Value of 31, 32, or 54 will indicate LTC.
53	Quantity Prescribed	Not Used

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Block Number	*Field Description*	*Guidelines*
54	Diagnosis Code	Enter code identifying the diagnosis of the patient.
55	Diagnosis Code Qualifier	Enter diagnosis code qualifier. 0 – ICD- 10 9- ICD - 9
56	(DUR/PPS CODES) Reason for Service Code	Enter the reason for service code. DD - Drug-Drug Interaction ER = Overuse HD - High Dose LD - Low Dose LR - Underuse PA - Drug-Age PS - Product Selection TD - Therapeutic Duplication
57	(DUR/PPS CODES) Professional Service Code	Enter the professional service code. 00 - No intervention M0 - Prescriber consulted P0 - Patient consulted R0 - Pharmacist consulted other source
58	(DUR/PPS CODES) Result of Service Code	Enter the result of service code. 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 Drug 1F - Filled, With Different Quantity 1G - Filled, With Prescriber Approval 1H - Brand-to-Generic Change 1K = Filled with Different Dosage Form 2A - Prescription Not Filled 2B - Not Filled, Directions Clarified
59	Level of Effort	Not Used.
60	Procedure Modifier	Not Used.
61	Other Payer ID	Enter the ID assigned to the payer. Fields (61-63) 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.
62	Other Payer ID Qualifier	Enter the other payer ID qualifier. 01 = National Payer ID 1C = Medicare Number 1D = Medicaid Number 02 = Health Industry Number (HIN) 03 = Bank Information Number (BIN) 04 = National Association of Insurance Commissioners (NAIC) 05 = Medicare Carrier Number 99=Other
63	Other Payer Date	Enter payer date in format MMDDCCYY.
64	Other Payer Rejects	The appropriate NCPDP other coverage reason code must also be indicated. If the other insurance did not make a payment, the dollars/cents field should be zero, but the NCPDP other coverage reason code must be included. See NCPDP D.0 Data Dictionary for appropriate codes.
65	Other Payer ID	Fields (65-67) 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.

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Block Number	*Field Description*	*Guidelines*
66	Other Payer ID Qualifier	Enter the other payer ID qualifier. 01 = National Payer ID 1C = Medicare Number 1D = Medicaid Number 02 = Health Industry Number (HIN) 03 = Bank Information Number (BIN) 04 = National Association of Insurance Commissioners (NAIC) 05 = Medicare Carrier Number 99=Other
67	Other Payer Date	Enter payer date in format MMDDCCYY.
68	Other Payer Rejects	The appropriate NCPDP other coverage reason code must also be indicated. If the other insurance did not make a payment, the dollars/cents field should be zero, but the NCPDP other coverage reason code must be included. See NCPDP D.0 Data Dictionary for appropriate codes.
69	Dosage Form Description Code	If fields 73-78 have data enter the compound dosage form description code. Blank=Not Specified 01 = Capsule 02 = Ointment 03 = Cream 04 = Suppository 05 = Powder 06 = Emulsion 07 = Liquid 10 = Tablet 11 = Solution 12 = Suspension 13 = Lotion 14 = Shampoo 15 = Elixir 16 = Syrup 17 = Lozenge 18 = Enema
70	Dispensing Unit Form Indicator	If fields 73-78 have data enter dispensing unit form indicator. 1 = Each 2 = Grams 3 = Milliliters
71	Route of Administration	This is an override to the “default” route referenced for the product. For a multi-ingredient compound, it is the route of the complete compound mixture. If fields 73-78 have data enter appropriate information. Systematized Nomenclature of Medicine Clinical Terms® (SNOMED CT) SNOMED CT® terminology which is available from the College of American Pathologists, Northfield, Illinois http://www.snomed.org/
72	Ingredient Component Count	If fields 73-78 have data enter count of compound product IDs (both active and inactive) in the compound mixture submitted.
73	Product Name	Enter the product name of the ingredient being submitted. (If fields 41-44 contain data fields 73 – 78 should be blank).
74	Product ID	Enter the NDC code of the drug that is submitted.
75	Qualifier	Enter Product/Service ID Qualifier 03 – NDC

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Block Number	*Field Description*	*Guidelines*
76	Ingredient Quantity	Enter the quantity or number of units dispensed. There are three dispensing units: • Each (ea): tablets, capsules, suppositories, patches, and insulin syringes. For example, one package of Loestrin should be coded on the claim form as 00021. • Milliliter (ml): Most suspensions and liquids will be billed per milliliter. Most injectables that are supplied in solution are also billed per milliliter. For example, a 5ml of ophthalmic solution should be coded 00005. • Gram (gm): Most creams, ointments, and powders will be billed per gram. For example, a 45gm tube of ointment should be coded as 00045. **If a product is supplied in fractional units (for instance, a 3.5gm tube of ointment), Medicaid providers should submit claims involving decimal package sizes for the exact amount being dispensed. In this example, the quantity billed should be 0003.5**
77	Ingredient Drug Cost	Enter ingredient cost for the metric decimal quantity of the product included in the compound mixture indicated in field 76.
78	Basis of Cost	Enter the code indicating the method by which the drug cost of an ingredient used in a compound was calculated. 00 =Default 01 = AWP (Average Wholesale Price) 02 = Local Wholesaler 03 = Direct 04 = EAC (Estimated Acquisition Cost) 05 = Acquisition 06 = MAC (Maximum Allowable Cost) 07 = Usual & Customary 08 = 34ØB /Disproportionate Share Pricing/Public Health Service 09 = Other 10 = ASP (Average Sales Price) 11 = AMP (Average Manufacturer Price) 12 = WAC (Wholesale Acquisition Cost)
79	Usual & Customary Charge	Enter the amount (dollars and cents) of your customary charge.
80	Basis of Cost Determination	Enter the code indicating the method by which the drug cost of an ingredient used in a compound was calculated. 00 =Default 01 = AWP (Average Wholesale Price) 02 = Local Wholesaler 03 = Direct 04 = EAC (Estimated Acquisition Cost) 05 = Acquisition 06 = MAC (Maximum Allowable Cost) 07 = Usual & Customary 08 = 34ØB /Disproportionate Share Pricing/Public Health Service 09 = Other 10 = ASP (Average Sales Price) 11 = AMP (Average Manufacturer Price) 12 = WAC (Wholesale Acquisition Cost)
81	Ingredient Cost Submitted	Enter total amount that will be paid for the drug dispensed.
82	Dispensing Fee Submitted	Not Used.
83	Professional Service Fee Submitted	Not Used.

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Block Number	*Field Description*	*Guidelines*
84	Incentive Amount Submitted	Amount represents a fee that is submitted by the pharmacy for contractually agreed upon services. This amount is included in the 'Gross Amount Due' field 87.
85	Other Amount Submitted	Enter amount representing the additional incurred costs for a dispensed prescription.
86	Sales Tax Submitted	Not Used.
87	Gross Amount Due (Submitted)	Enter total price claimed from all sources. For prescription claim request, field represents a sum of 'Ingredient Cost Submitted' (field 81), 'Dispensing Fee Submitted' (field 82), 'Flat Sales Tax Amount Submitted' (field 86), 'Incentive Amount Submitted' (field 84), and 'Other Amount Claimed' (field 85).
88	Patient Amount Paid	Not Used
89	Other Payer Amount Paid #1	Enter amount paid by payer 1 (field 61).
90	Other Payer Amount Paid #2	Enter amount paid by payer 2 (field 65).
91	Other Payer-Patient Responsibility Amount 1	Enter the patient's cost share from payer 1.
92	Other Payer-Patient Responsibility Amount 2	Enter the patient's cost share from payer 2.
93	Net Amount Due	Not Used.

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5.6 Completing the Medical Medicaid/Medicare Related Claim Form

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

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

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5.6.1 Medical Medicaid/Medicare-related Blank Claim Form

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

MEDICAL MEDICAID/MEDICARE RELATED CLAIM

1. RECIPIENT INFORMATION

a. Medicaid ID	
b. First Name	
c. Last Name	
d. Med. Rec. #	
e. Patient Acct. # (Optional)	

2. OTHER INSURANCE INFORMATION

a. Covered by other insurance (Except Medicare)? Enter Y if yes or N if no	
b. If other insurance rejected, attach rejection to completed claim and mail to HP and enter date TPL was denied here (MM/DD/YY).	
c. If other insurance paid, attach the completed Medicaid Other Insurance Attachment form (ALTPL01) and mail to HP.	

3. DIAGNOSIS CODES

A._____ B._____ C._____ D._____ E._____ F._____

G._____ H._____ I._____ J._____ K._____ L._____

4. VERSION: 9=ICD-9, 0=ICD-10	

5. DETAIL OF SERVICES PROVIDED

	a. DATES OF SERVICE FROM	THRU	b. POS	c. NDC d. PROCEDURE CODE	e. UNIT	f. MOD	g. DIAG PTR	h. CHARGES	MEDICARE i. ALLOWED	j. COINS.	k. DEDUCTIBLE	l. PAID
1												
2												
3												
4												
5												
6												
7												
8												
9												
6. TOTALS								a.	b.	c.	d.	e.

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 is less than 120 days old.

7. Billing Provider Name	a.			
7. Billing Provider ID	b. NPI	c. Taxonomy	d. Qu	e. Secondary ID
8. Performing Provider Name	a.			
8. Performing Provider ID	b. NPI	c. Taxonomy	d. Qu	e. Secondary ID

Submit completed claim to:

HP
Post Office Box 244032
Montgomery, AL 36124-4032

9. Billing Provider mailing address required in block below:

Form 340 Revised 10/12

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5.6.2 Medical Medicaid/Medicare-related Claim Filing Instructions

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

NOTE:

When a recipient is enrolled in a Medicare Advantage plan and Medicaid has not paid a monthly capitation payment, professional service providers must use the Medical Medicaid/Medicare-related claim form when billing Medicaid for Medicare Advantage plan deductibles, coinsurances, or co-pays. These claims will be processed by Medicaid in the same manner as a Medicare paid claim. Medicare Advantage deductibles, coinsurance, and co-pays should be reported on the crossover claim in the appropriate Medicare field.

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

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

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

Block Number	*Field Description*	*Guidelines*
1	Recipient Information	a. Enter the recipient's 13-digit RID number. Effective January 17, 2011, the Alabama Medicaid Agency is phasing out the acceptance of the old Medicaid ID Number (number beginning with '000"). Only the new Medicaid ID number (number beginning with a "5") will be accepted for claims processing purposes for claims received on or after January 17, 2011. b. Enter the recipient's first name. c. Enter the recipient's last name. d. Enter the recipient's medical record number. (Optional) e. Enter recipient's patient account number (to be referenced on the Remittance Advice (RA) for patient identification). Up to 20 characters may be entered into this field. (Optional)
2	Other Insurance Information	a. Covered by other insurance (Except Medicare)? Enter Y if yes or N if no b. If other insurance rejected attach rejection to completed claim and enter date TPL was denied (MM/DD/YY) c. If other insurance paid attach TPL form (ALTPLO1) to the claim.
3	Diagnosis Codes	A. - L. 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.
4	Version	Enter 9 for ICD-9 or ICD-10 diagnosis codes

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Block Number	*Field Description*	*Guidelines*
5	Detail of Services Provided	a. Enter the from and through dates in MMDDYY format. b. Enter the two-digit place of service as filed to Medicare. c. Enter identifier N4 and the National Drug Code (NDC) for the procedure, if required. d. Enter the five-digit procedure code. e. Enter the number of units of service. f. Enter the modifiers for the procedure code. Enter up to 4 modifiers. g. Enter diagnosis pointer (Ex. Enter A or B) h. Enter the charge for each line item. i. 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. a. Enter the sequestration reduction j. Enter the Medicare coinsurance amount for each line item. **Do not enter Medicaid copayment amount. Do not enter Medicare payments.** b. Enter the eRX reduction k. Enter the amount applied to the Medicare deductible for each line item. c. Enter the Medicare Copay l. Enter the Medicare paid amount for each line item *FQHC, PBRHC, and IRHC should enter the Medicare per diem paid amount for each line item.
6	Totals	a. Total for charges. b. Total for allowed amount. c. Total for coinsurance amount. d. Total for deductible amount. e. Total for paid amount.
7	Billing Provider Name	a. Enter the billing/payee provider name.
7	Billing Provider ID	b. NPI: Enter the NPI of the billing/payee provider c. Taxonomy: Enter the taxonomy code of the billing provider (optional) d. Qu: Enter the appropriate qualifier code for the secondary identifier. If using the legacy Medicaid provider number, use qualifier code “1D”. e. Secondary ID: Enter the secondary identifier for the billing provider ID. The secondary identifier should be the legacy Medicaid provider number. This is an optional field, but is required for providers with multiple service locations.
8	Performing Provider Name	a. Enter the name of the provider which performed the service.

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Block Number	*Field Description*	*Guidelines*
8	Performing Provider ID	b. NPI: Enter the NPI of the provider which performed the service. c. Taxonomy: Enter the taxonomy code for the provider which performed the service. (Optional) d. Qu: Enter the appropriate qualifier code for the secondary identifier. If using the legacy Medicaid provider number, use qualifier code "1D". e. Secondary ID: Enter the secondary identifier for the performing provider. The secondary identifier should be the legacy Medicaid provider number of provider which rendered the service. This is an optional field, but is required for providers with multiple service locations.
9	Provider Mailing Address required in block below	Enter the billing address, city, state, and zip code for the rendering (performing) provider.

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

5.7 Required Attachments

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

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

NOTE:

Third party denials must be attached with the claim and sent hard copy, if the denial code is not on the list of codes that may be submitted electronically. The list is at this link, https://medicaid.alabama.gov/documents/7.0_Providers/7.1_Benefit_Coordination_3rd_Party/7.1_TPL_Denial_Reasons_Accepted_Revised_5-1-20.pdf

NOTE:

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

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5.7.1 TPL Attachment Forms

Providers are to submit TPL forms when third party payment is made. These forms are scanned and matched electronically with the related claims before processing.

5.7.1.1 TPL Attachment Blank Form

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

MEDICAID
OTHER INSURANCE ATTACHMENT

1. Billing Provider ID	a. NPI	Name	b.
2. Medicaid ID	a.	Name	b.

3. List other payors in order of responsibility. Sequence 1=Primary, 2=Secondary, 3=Tertiary

SEQ	a. HEALTH PLAN ID	b. PAYOR NAME AND ADDRESS	c. POLICY NUMBER	d. DATE PAID
1.				
2.				
3.				

4. Indicate TPL payment amounts per claim detail. (Note: For header amount on Institutional claims use detail number 0.)

a. DTL	b. PAYOR SEQ	c. COPAY	d. COINSURANCE	e. DEDUCTIBLE	f. TPL PAID

Submit completed claim to:

HP
Post Office Box 244032
Montgomery, AL 36124-4032

Form ALTPL-01 10/12

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5.7.2 TPL Attachment Filing Instructions

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

Block Number	***Field Description***	***Guidelines***
1	Billing Provider ID	a. Enter billing Provider NPI b. Enter billing Provider name
2	Medicaid ID	a. Enter recipient Medicaid ID b. Enter the recipient full name
3	List of Payors	Enter the following information in order of responsibility: a. Health Plan ID b. Payor name and Address c. Policy Number d. Date Paid
4.	TPL payment amounts	Enter the TPL amounts per claim detail. **Note**: For header amount on institutional claims use detail number 0. a. Detail number b. Payor sequence c. Copay amount d. Coinsurance amount e. Deductible amount f. TPL paid amount Note: Sequence 1= Primary, 2= Secondary, 3= Tertiary

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5.8 Required Consent Forms

Consent forms are no longer required attachments with the claim form and must be uploaded or faxed via the Forms menu of the Alabama Medicaid Interactive Web Portal. Refer to Chapter 28 for details regarding the regarding the Hysterectomy and Abortion Consent Form. Details regarding the Sterilization Consent Form can be located in Appendix C. The accompanying claim may be sent electronically.

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.

5.8.1 Digital Submission of Consent Forms and Supporting Documentation

Effective October 26, 2016, providers will be able to upload or fax their fillable Consent Forms (Abortion, Hysterectomy, and Sterilization) and supporting documentation for review and processing via the Forms menu of the Alabama Medicaid Interactive Web Portal. A new form will allow providers the ability to upload Consent Forms and supporting documents in PDF format or create a fax barcode cover sheet from the Web Portal. Providers may submit additional documentation via fax at a later time and have that documentation combined with original document through the use of the same barcode cover sheet.

Important Notice for Microsoft Edge Users

For providers using Microsoft Edge the following process should be used to successfully complete a fillable PDF Consent form:

1. Open the form from the Medicaid Forms Library page.
2. Save the form to personal computer (PC).
3. Complete the form from the PC version (not the web browser).
4. Follow **Steps to Upload Documentation** section of this article to complete the submission process.

Accessing the Medicaid Interactive Web Portal

A secure logon to the Alabama Medicaid Interactive Web Portal is required to access the new attachment option. Consent Form and supporting documentation may be submitted in two different ways:

- Upload via Medicaid Interactive Web portal (preferred) https://www.medicaid.alabamaservices.org/ALPortal/Account/Secure%20Site/tabId/66/Default.aspx
- Fax information using barcode cover sheet

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Browser Compatibility

Follow the below instructions to set your browser compatibility settings for use with the Medicaid Interactive Web portal:

- Navigate to the Medicaid Interactive Web Portal using the URL provided above.
- Select **Tools** from upper right hand corner of browser. The feature is displayed as a wheel. 
- Choose **Compatibility View Settings**.
- Click **Add**.
- Click **Close**.
- Refresh Browser to apply setting.

Documents must be in a PDF

Documents must be in a PDF for upload through the Web Portal. If you do not currently have the ability to create PDF versions of supporting documentation, you may perform an internet search and find free downloadable utilities that can be installed to create a PDF. For your convenience, Gainwell is including a list of three PDF creation utilities that can be installed to create PDF documents at no charge:

- PrimoPDF - http://www.primopdf.com/
- Solid PDF Creator - http://www.freepdfcreator.org/
- PDF24 - http://pdf24-pdf-creator.en.softonic.com/

Steps to Upload Documentation

Follow the steps below to upload through the Web Portal. Failure to follow the steps will result in delays in approval and corresponding reimbursements/payments.

1. Log on to Medical Interactive Web portal: https://www.medicaid.alabamaservices.org/ALPortal/Account/Secure%20Site/tabId/66/Default.aspx
2. Select **Trade Files/Forms**.
3. Select **CS1 – Consent Form** from the drop down list and click on **Search**.
4. Complete all fields (Record ID and ICN fields will auto populate). Required fields are indicated with an asterisk (*).

   a) **Recipient Medicaid ID** - Number must be numeric and contain 13 characters.
   b) **Form Type** – Select Abortion, Hysterectomy, and Sterilization from the drop down list.
   c) **Date of Surgery** – Must be in XX/XX/XXXX format.

5. Click **Browse** and select the required consent form or supporting documentation from your network drive or PC.
6. Review all the values entered for completion and accuracy as no further updates will be allowed once the Submit button is pressed. **Note: If any error messages are presented, resolution of the identified errors are required to complete submission.**

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7. Press **Submit**.
8. A message will be generated at the top of the page that states “Your form was submitted successfully”.
9. A barcode cover sheet is generated and will be displayed. *It is imperative that you **save** a copy of this cover sheet should you be requested to submit additional documentation for this packet.*
10. Select the **Print Friendly View** button to print the barcode cover sheet.

Steps to Fax Documentation

If a PDF document cannot be created, information may also be faxed in for review. A barcode fax cover sheet is *required* with each submission. Providers should follow the instructions below to fax documentation:

1. Follow steps 1-10 documented above.
2. Include the barcode cover sheet as page one of the fax transmission for the corresponding Record ID. Any articles related to this recipient/surgery must use the same barcode cover sheet.
3. Fax the required documentation with the barcode cover sheet on top to (334) 215-7416.
   Important: Barcode cover sheets are unique to **each** Record ID. **DO NOT** use it for another Record ID.
4. **DO NOT** place anything over the barcode on the cover sheet or alter it in any manner.
5. **DO NOT** fax double sided pages.
6. **DO NOT** fax multiple sets of records at the same time, each fax should be sent separately.

Providers with questions concerning the upload supporting documentation should contact one of their Provider Representatives. A link to the Provider Representative’s contact information may be found at the following link:
http://medicaid.alabama.gov/content/10.0_Contact/10.3_Provider_Contacts.aspx

5.9 Adjustments

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

5.9.1 Online Adjustments

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

To submit electronic online adjustments, providers must use accurate information relating to the previously paid claim. The Gainwell Provider Electronic Solutions software or provider’s vendor system will require that provider submit a new (837) Professional,

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Institutional or Dental transaction, with *Original Internal Control Number (ICN)* field populated. This electronic adjustment claim will be assigned a new ICN number with a region of 52.

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

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

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

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

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

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

5.10 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:

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

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

- Provider Name and NPI
- Your check number, check date, check amount
- 13-digit claim number or ICN (from RA)
- Recipient’s Medicaid ID number and name (from RA)

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- Dates of service
- Date of Medicaid payment
- Date of service being refunded
- Services being refunded
- Amount of refund
- Amount of insurance received, if applicable (third party source other than Medicare)
- Insurance name, address and policy number
- Reason for return (from codes listed on form)
- Signature, date and telephone number

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

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

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

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

5.11 Inquiring about Claim and Payment Status

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

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

Calling AVRS

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

Contacting the Gainwell Provider Assistance Center

The Gainwell 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.

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It is recommended that you use AVRS, Provider Electronic Solutions Software or access the Alabama Medicaid Agency Interactive Services website before calling the Gainwell Provider Assistance Center. To ensure the Assistance Center is available to all providers, Gainwell must limit providers to three transactions per telephone call. Through AVRS, however, providers may perform up to ten inquiries, including prior authorization requirements, claim status inquiries, and multiple eligibility verification requests.

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

Contacting Gainwell in Writing

Providers may contact Gainwell in writing to resolve more complex billing issues. This correspondence will be reviewed by Gainwell Provider Relations, which is composed of field representatives who are expert in Medicaid billing policy. Gainwell 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 Gainwell Provider Assistance Center is fully staffed during regular business hours, and can receive, resolve, or forward all billing and claim-related calls, ensuring they are answered in a timely fashion. Provider Representatives, who provide responses to written requests, travel on a regular basis, providing billing assistance to the Alabama Medicaid provider community. It is therefore recommended that providers contact the Provider Assistance Center to begin the inquiry process, and follow up with written correspondence as the need arises.

Accessing the Alabama Medicaid Agency Interactive Services Website

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

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

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6 Receiving Reimbursement

This chapter describes the Remittance Advice (RA) report and the reimbursement schedule for Medicaid fee-for-service claims. A RA is an explanation of payment and claims processed in either a proprietary format or the HIPAA 835 transaction. Information in this section is in accordance with Alabama Medicaid Agency policy and procedure as well as Section 1104, Administrative Simplification, of the Affordable Care Act (Operating Rules) which includes Electronic Fund Transfer (EFT) and Electronic Remittance Advice (ERA).

Effective July 2015:

All billing providers must be enrolled to receive an 835/ERA (electronic remittance advice). If already enrolled to receive 835s you do not need to re-enroll. For providers newly enrolling in Medicaid and/or enrolling a new site with Medicaid, the 835/ERA enrollment is part of the standard enrollment application.

Alabama Medicaid will begin releasing ERA/835's within three (3) business days (plus or minus) of the EFT being released. This is a change to current day processes where the 835/ERA is made available to providers even when funds related to the 835/ERA have not yet been released.

Note: There is currently no change to the availability of the proprietary RA which will continue to be available on the web portal following each check write cycle. Providers will also receive a 277U (Unsolicited) transaction along with their proprietary RA. The Unsolicited Claim Status transaction, returned once a claims payment cycle has completed, reports all claims adjudicated to a suspended status.

NOTE:

Reimbursement information specific to managed care is described in Chapter 40 Alabama Coordinated Health Network (ACHN) of this manual.

6.1 Remittance Advice (RA) Report

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

Effective March 1, 2010, Medicaid no longer prints and distributes paper RAs to providers. A provider can receive an electronic copy of the RA or download a copy from the WEB. The electronic copy is the 835 Health Care

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Claim Payment/Advice. The electronic media has been expanded to include more information. Providers wishing to receive the 835 must be assigned a 'submitter ID" and an indicator must be set in the system to generate the electronic report. *The Electronic Remittance Advice Agreement Form is available on the Alabama Medicaid website.* All payee providers (individuals not within a group, groups and facilities) must also be enrolled in EFT.

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 Gainwell Provider Assistance Center at 1(800) 688-7989. To request an adjustment of a previously paid claim, refer to Section 5.10, Adjustments, for more information.

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

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

6.1.1 Provider Remittance Advice (RA)

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

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

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

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

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

First Page

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

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Paid Claims

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

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

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

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

Denied Claims

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

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

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

Claims In Process

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

RA Claim Page Field Descriptions

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

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

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

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Field	*Description*
Name	Displays the recipient's last name, and first name. Claims are displayed in alphabetical order by last name.
Pat Acct No.	Displays the Patient Account Number assigned to the recipient by the provider.
ICN	Displays the internal control number of the claim. Use this number when inquiring about the claim.
MRN	Displays the Medical Record Number assigned to the recipient by the provider.
Rendering Provider	Displays the National Provider Identifier (NPI) of the rendering provider.
Attending ID	Displays the National Provider Identifier (NPI) of the attending physician, if applicable.
Recipient ID	Displays the 12 digit recipient Medicaid ID number as submitted by the provider.
Admit Date	Displays the admitting date submitted on the claim, if applicable.
Dispense Date	Displays the dispense date submitted on the claim, if applicable.
Days	Displays the number of days submitted on the claim, if applicable.
Dates Of Service First Date Of Service - Last Date Of Service,	Displays the dates of service submitted on the claims in MMDDYY format. This displays for each line item billed, if applicable.
Dist Plan (District Plan)	Displays the District Plan Code for the inpatient claim, if applicable
Surf (Tooth Surface)	Displays the tooth surface on the detail line, if applicable.
POS Or PL SERV (Place Of Service)	Displays the place of service as submitted on the claim, if applicable.
TN (Tooth Number)	Displays the tooth number on the detail line, if applicable.
Procedure/Revenue/ NDC Code	Displays these codes as they were submitted on the claim. This displays for each line item billed, if applicable.
Modifiers	Displays the procedure code modifiers as they were submitted on the claim.
Desc	Displays the first six characters of the NDC code description
Billed Amount	Displays the amount billed on the claim. This displays for each line item billed, if applicable.
Non Allowed	Displays the amount of the billed amount that Medicaid will not cover. This displays for each line item billed, if applicable.

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Field	*Description*
Allowed Amount	Displays the amount of the billed amount that Medicaid will cover. This displays for each line item billed, if applicable.
Patient Liability	This displays the patient liability applied to the claim payment, if applicable.
TPL Amount	Displays the amount paid by a third party insurance. This displays for each line item billed, if applicable.
Paid Amount	Displays the amount Medicaid paid the provider for the claim. This displays for each line item billed, if applicable.
HEADER And DETAIL EOBS	Displays an Explanation Of Benefit code about claim adjudication. This displays for each header and line item billed, if applicable.
Copay Amount	This displays the copay applied to the claim payment, if applicable.
QTY Or UNITS	Displays the quantity or units submitted.
Rx No.	Displays the prescription number.
Total Billed	Displays the total billed for all the claim.
Total Non-Allowed	Displays the total payment that Medicaid will not cover for all the claims.
Total Allowed	Displays the total allowed amount for all the claims.
Total Patient Liability	Displays the total patient liability for all the claims.
Total Copay Amount	Displays the total copay for all the claims.
Total TPL Amount	Displays the total TPL for all the claims.
Total Paid Amount	Displays the total amount of Medicaid payment for the claims.

Adjusted Claims

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

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

Financial Transactions Page

There are three sections:

- Payouts: This lists non-claim expenditures made to the provider.

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

Summary Page

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

Payment reporting is displayed as follows:

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

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

NOTE:

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

Third Party Insurance Information

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

EOB Codes

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

Encounter Data

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

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6.2 Reimbursement Schedule

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

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

EFT is the required method to deposit funds for claims for payment. These funds can be credited to either checking or savings accounts, directly into a provider's bank account, provided the bank selected accepts Automated Clearing House (ACH) transactions. EFT also avoids the risks associated with mailing and handling paper checks, ensuring funds are directly deposited into a specific account.

The following items are specific to EFT:

- The release of direct deposits depends on the availability of funds. EFT funds are released as directed by the Alabama Medicaid Agency. The earliest funds are available is Saturday mornings following the checkwrite.
- Pre-notification to your bank takes place following the application processing. The pre-notification process takes place over a time frame of twenty-one (21) days. Direct deposits when owed to a provider will be made according to the release guidelines in the bullet above. The 835/RA (Remittance Advice) furnishes the details of individual payments made the provider's account during the weekly cycle.
- The availability of the proprietary RA reports is unaffected by EFT and are typically received by the end of the week following the checkwrite.

Gainwell must provide the following notification according to ACH guidelines:

> "Most receiving depository financial institutions receive credit entries on the day before the effective date, and these funds are routinely made available to their depositors as of the opening of business on the effective date.

However, due to geographic factors, some receiving depository financial institutions do not receive their credit entries until the morning of the effective date and the internal records of these financial institutions will not be updated. As a result, tellers, bookkeepers, or automated teller machines (ATM) may not be aware of the deposit and the customer's withdrawal request may be refused. When this occurs, the customer or company should discuss the situation with the ACH coordinator of their institution who, in turn, should work out the best way to serve their customer's needs."

The effective date for EFT under the Alabama Medicaid Program is based on the release of funds as directed by the Alabama Medicaid Agency. The earlier effective date is Saturday following the checkwrite (if funds were made available from the Agency for the particular provider).

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6.3 Rule 370 Resolving Late or Missing EFT or ERA/835

Providers *may* receive their 835/ERA immediately following the financial check write cycle if one of two conditions occur:

1. There is zero or negative payment on the 835/ERA (no EFT will be generated for this 835/ERA), or:
2. The provider receives paper checks rather than EFT during the pre-note EFT verification process.

If you determine an EFT or 835/ERA is late or missing there are some initial steps to take:

- **Contact your financial institution -** If you determine you have not received your EFT within three (3) business days of your 835/ERA, contact your financial institution. Once funds are released Alabama Medicaid has no way to track funds through your bank.
- **Contact your trading partner** - If you determine you have not received your 835/ERA within three (3) business days of your EFT, contact your trading partner. Alabama Medicaid produces 835/ERAs for your trading partner who will then distribute your information directly to you.

If you determine there is not an issue with your financial institution distributing funds, and/or there is not an issue with your trading partner distributing the 835/ERA to you, there are additional steps you can follow to resolve late or missing EFT and 835/ERA transactions:

1. Rule 370, Section 6.3 Resolving Late or Missing EFT and ERA Transaction Resolution procedures only apply when an EFT and/or 835/ERA enrollment has been set up.
    - If you have not set up 835/ERA, please follow the below steps:
        - If you **DO NOT** have a trading partner ID, visit the Alabama Medicaid Interactive Portal at: https://www.medicaid.alabamaservices.org/alportal/Tab/41/content/InformationLinks/InformationLinks.html.spage. Click on Information/Alabama Links and download the trading partner ID Request Form. Complete the appropriate sections and submit to the Electronic Media Claims (EMC) Help Desk as directed on the form.
        - If you **DO** have a trading partner ID visit the **Administrative Forms** section of the Alabama Medicaid website at http://medicaid.alabama.gov/content/9.0_Resources/9.4_Forms_Library.aspx. Click on Provider Enrollment. Download the Electronic Remittance Agreement. Complete the appropriate sections and submit to the EMC Help Desk as directed on the form.
        - If you have not set up EFT to deposit funds for claims approved for payment please refer to the Alabama Medicaid Agency's website for EFT enrollment information at: http://medicaid.alabama.gov/content/9.0_Resources/9.4_Forms_Library.aspx. Click on Provider Enrollment. Download the Electronic

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Funds Transfer Agreement. Complete the appropriate sections and submit to the EMC Help Desk as directed on the form.

- Effective December 2016, the submission process for the required EFT enrollment supporting documentation will be updated to allow providers to upload or fax supporting information via the Forms menu on the Alabama Medicaid Interactive Web Portal. The provider may upload enrollment supporting documents such as EFT supporting documentation in PDF format or create a fax barcode coversheet from the Web Portal.

NOTE:

Providers must maintain this barcode coversheet to submit additional documentation via fax at a later time and have that documentation combined with their original documents. Detailed instructions for digital submission of enrollment supporting documentation will be made available within the Forms Library on the Alabama Medicaid website and the Forms menu on the Alabama Medicaid Interactive Web Portal.

2. Ensure enough time has elapsed to receive the EFT or 835/ERA. Providers can expect their 835/ERA to become available within three business days (plus or minus) of the EFT being released.
3. Allow a minimum of two (2) check write cycles or 30 days to receive funds electronically if a bank account was recently updated or enabled.
4. Confirm that you have contacted your bank to receive the Re-Association information on your EFT.
5. Verify the correct Re-association Trace Number is being used to correlate the 835/ERA with the payment. The Re-association Trace Number can found on the 835/ERA (TRN02).
6. Verify the trading partner ID associated with the EFT and 835/ERA is correct as providers may have multiple trading partner IDs. Providers should also be aware if they change their trading partner ID, any 835/ERA files produced prior to such a change will go to the previous trading partner.
7. Providers may receive 835/ERA files for a single check write cycle over the course of multiple days, as 835/ERA files will become available as funds are released. Providers can use proprietary RA, 276/277 (claim status request and response), Automated Voice Response System (AVRS), or Provider Electronic Solutions (PES) for claim and check/payment information.

If the above information has not produced an answer to the late or missing EFT or 835/ERA, please contact the EMC Help Desk at (800-456-1242), Monday – Friday, 7:00 a.m. – 8:00 p.m. CST, or Saturday, 9:00 a.m. – 5:00 p.m. CST.

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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
- Provider Rights
- Medicare/Medicaid Fraud and Abuse Policy
- Appeals
- Refunds

7.1 Provider Responsibilities

Medicare and Medicaid authorize payment only when the items or services are medically necessary. Medical necessity is determined on a case by case basis and consistent with the criteria outlined in section 7.1.1 “Medical Necessity/ Medically Necessary Care”. 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.*

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7.1.1 Medical Necessity/Medically Necessary Care

Medical Necessity" or "Medically Necessary Care" means any health care service, intervention, or supply (collectively referred to as "service") that a physician (or psychologist, when applicable), exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, [including mental illnesses and substance use disorders], injury, disease, condition, or its symptoms, in a manner that is:

- in accordance with generally accepted standards of medical practice;
- clinically appropriate in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury, disease, or condition;
- in accordance with medical necessity "guidelines/references" in Agency's Administrative Code, State Plan, and Provider Manual;
- not primarily for the convenience of the patient or Provider;
- not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, disease, or condition.
- the service is not contraindicated; and
- the Provider's records include sufficient documentation to justify the service.

For these purposes, "generally accepted standards of medical practice" means:

- Standards that are based on credible scientific evidence published in peer reviewed medical literature generally recognized by the relevant medical community are required when applicable; or
- Alternatively, may consider physician specialty society recommendations [clinical treatment guidelines/guidance] and/or the general consensus of physicians practicing in relevant clinical areas.

Application of medical necessity is unique with regard to Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit/services. All full benefit eligible Medicaid enrollees under age twenty-one (21) may receive EPSDT benefit/services in accordance with sections 1905(a) and 1905(r) of the Social Security Act. Included are services identified as a result of a comprehensive screening visit or an inter-periodic screening, regardless of whether or not they are ordinarily covered for all other Medicaid Enrollees. Additionally, all services necessary to correct or ameliorate a physical or mental illness or condition are included.

The fact that a Provider has prescribed, recommended, or approved services does not, in itself, make such services medically necessary, a medical necessity, or a Covered Service.

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At Agency's request, the Provider must submit the written documentation to comply with "generally accepted standards of medical practice" as defined within the medical necessity definition.

Experimental and cosmetic procedures are only allowed in limited circumstances as outlined in Agency's Administrative, Code Chapter 6, Rule No. 560-X-6-.13 Covered Services: Details on Selected Services.

7.1.2 Maintenance of Provider Information

Providers must promptly advise the Gainwell Provider Enrollment Department of changes in address (physical or accounting), telephone number, name, ownership status, tax ID, and any other information pertaining to the structure of the provider's organization (for example, rendering providers). Most updates can be made via the provider web portal or by submitting information via the Medicaid Interactive Web Portal. Note that change of ownership information should be submitted as outlined below in section 7.1.3.

Licensure updates for Alabama licensed providers are normally received via an electronic update from the licensing board; however, if a provider misses the deadline for renewal of their license, their information will not be included in the electronic update. Providers who miss their license renewal deadline must submit a paper (PDF version) copy of their renewed license via the Medicaid Interactive Web Portal. Medicaid does not receive any electronic updates for Out-of-State (OOS) licensees; therefore, OOS licensees must submit license renewal updates via the portal as well.

Failure to notify Gainwell of changes affects accurate processing and timely claims payment.

7.1.3 Reporting Change of Ownership Information

Medicaid requires the owner of a Medicaid enrolled facility to report any change of ownership or closure to Medicaid as soon as Medicare has been notified.

Currently enrolled providers are required to complete the Change of Ownership Information form and mail to the Enrollment and Sanctions Unit, Program Integrity Division, Alabama Medicaid Agency, 501 Dexter Avenue, Montgomery, Alabama 36103. This form can be obtained by accessing Medicaid's website at https://medicaid.alabama.gov/documents/9.0_Resources/9.4_Forms_Library/9.4.16_Provider_Enrollment/9.4.16_PE_CHOW_Form_8-20-18.pdf.

Change of Ownership (CHOW) and Closures

Medicaid will mirror Medicare's Change of Ownership (CHOW) policy. Refer to Chapter 19, Hospital for additional information on Change of Ownership.

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7.1.4 Retention of Records

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

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

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

The provider must be able to provide original records, upon request and at no charge to Medicaid, related state or federal agencies, or the Alabama Medicaid fiscal agent, Gainwell. Original records must be written according to practice guidelines and state/federal law and must include the date and signature of the provider, the service(s) ordered and the recipient's name. The provider's signature date must be near the provider's signature to designate the date the record was signed by the provider rendering the service.

When records are requested, providers must send all associated documentation that supports the services billed within the timeframe designated in the verbal or written request. Sometimes that information may come from a visit or test performed earlier than the timeframe of the review. Elements of a complete medical record may include but are not limited to:

- Physician orders and/or certifications of medical necessity
- Patient questionnaires associated with physician services
- Progress notes of another provider that are referenced in your own note
- Treatment logs
- Related professional consultation reports
- Procedure, lab, x-ray and diagnostic reports
- Billing provider notes to support the billed date of service
- Delivery logs/tickets
- Itemized statements/invoices
- Prescriptions

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Amended records

Documentation submitted for review may include amended records. Amended records are legitimate occurrences in the documentation of clinical services and include a late entry, an addendum and/or a correction to the medical record. Amended records must:

- clearly and permanently identify any amendment, correction or delayed entry as such,
- clearly indicate the date and author of any amendment, correction or delayed entry,
- clearly identify all original content, without deletion, and
- be amended prior to claims submission and/or medical record request.

(a) Late entry: A late entry supplies additional information that was omitted from the original entry. The late entry must:

1. include the date the document is amended,
2. be amended upon discovery of the omission but no more than 45 calendar days beyond the date of service, **and**
3. be entered only if the person documenting the late entry has total recall of the omitted information and signs the late entry.

(b) Addendum: An addendum is used to provide information that was not available at the time of the original entry. The addendum must:

1. be timely (no more than 45 days beyond the date of service)
2. include the current date (the date the document is amended),
3. include the reason for the addition or clarification of information being added to the medical record, **and**
4. be signed by the person making the addendum.

(c) Correction: The original content of the medical record should never be written over or otherwise obliterate the passage when an entry to a medical record is made in error. A correction to the medical record must include:

1. A single line through the erroneous information, keeping the original entry legible;
2. Signature or initial,
3. Date the deletion, **and**
4. Statement for the reason for correction above or in the margin. Document the correct information on the next line or space with the current date and time, making reference back to the original entry.

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Correction of electronic records should follow the same principles of tracking both the original entry and the correction with the current date, time, reason for the change and initials of person making the correction. When a hard copy is generated from an electronic record, both records must show the correction. Any corrected record submitted must make clear the specific change made, the date of the change, and the identity of the person making that entry.

Examples of falsifying records include:

- Creation of new records when or after records are requested for review,
- Back-dating entries,
- Post-dating entries,
- Pre-dating entries,
- Writing over,
- Adding to existing documentation (excluding appropriate late entry, addendum and/or correction entries), and/or
- Adding late signatures to the medical record beyond the short delay that occurs during the transcription process (45 calendar days beyond the date of service).

Provider Signatures

Unless otherwise specified, the provider signatures may be satisfied by a handwritten, electronic or digital signature. (For more details related to provider signature requirements, see Alabama Medicaid's Administrative Code Rule No. 560-X-1-.18 Provider and Recipient Signature Requirements.) Provider signatures must be legible and clearly identify the provider performing the billed service. Illegible provider signatures must be supported by a valid signature log or attestation statement to determine the identity of the author.

A valid signature log must include, at a minimum, the following:

- names of licensed staff providing services along with credentials,
- a typed list of each provider's name followed by every iteration of the provider's signature, and
- dates (date range) for which the provider was employed by the facility and/or provided services.

Failure to provide every iteration of a provider's signature may result in recoupment of funds paid by Alabama Medicaid when illegible signatures cannot be verified the submitted signature log.

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, the necessary records and information to Medicaid investigators, members of the Attorney General's staff, or other designated

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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).

7.1.5 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, Gainwell.

7.1.6 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.

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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

7.1.7 Utilization Control – General Provisions

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

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

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 along with recoupment of any identified overpayments. 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 Gainwell, 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.

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7.1.8 Provider Certification

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

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

Offering incentives and advertising discounts.

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

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

Medicaid payment can never be made directly to recipients.

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

Services must be reasonable and medically necessary.

Medicaid is continuously evaluating and updating medical necessity for claims payment. In an effort to ensure accurate coding and payment of claims, diagnosis/procedure code criteria is applied. The correct use of a CPT, ICD-9 or ICD-10 code alone does not guarantee coverage of a service. All services must be reasonable and necessary in the specific case and must meet the criteria of specific governing policies. Medical record documentation must support coding utilized in claim and/or prior authorization submission.

7.1.9 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

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

NOTE:

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

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

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

A provider may not bill Medicaid or the recipient for a service he/she did not provide, i.e., “no call” or “no show”, etc. Conditional collections from patients, made before Medicaid pays, which are to be refunded after Medicaid pays, are not permissible.

7.1.10 Payment Adjustment for Provider Preventable Conditions (PPC’s)

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

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

It is the responsibility of the provider to identify and report any PPC and not seek payment from Medicaid for any additional expenses incurred as a result of the PPC.

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

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

- The PPC must be reasonable preventable as determined by a root cause analysis or some other means.

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- The PPC must be within the control of the provider.
- The PPC must be clearly and unambiguously the results of a preventable mistake made and provider procedures not followed, and not an event that could otherwise occur.
- The PPC must result in significant harm. The OPPC's for considerations should be limited to those that yield a serious adverse result. Serious adverse result is defined as one that results in death, a serious disability or a substantial increase in the duration and/or complexity of care that is well beyond the norm for treatment of the presenting condition. A serious disability is defined as a major loss of function that endures for more than 30 days, is not present at the time services were sought and is not related to the presenting condition.
- Any process for identifying non-payable events must actively incorporate some element of case-by-case review and determination. While the source and cause of some adverse events may be clear, most would require further investigation and internal root cause analysis to determine the cause of the serious preventable event and to assign ultimate accountability.

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

All providers must report OPPCs via encrypted emailing of the required information to: AdverseEvents@medicaid.alabama.gov.

Reportable OPPCs include but are not limited to:

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

The following information is required for reporting:

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

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

7.1.11 340 B Entities

The Veterans Health Care Act of 1992 enacted section 340 B of the Public Health Services Act, "Limitation on Prices of Drugs Purchased by Covered Entities". This Section provides that a manufacturer who sells covered outpatient drugs to eligible 340B entities must sign a pharmaceutical pricing

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agreement with the Secretary of Health and Human Services in which the manufacturer agrees to charge to Medicaid a price for covered outpatient drugs that will not exceed the average manufacturer price decreased by a rebate percentage.

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

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

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

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

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

7.2 Provider Rights

This section describes the fair hearings process, informal conferences, appeals, and Gainwell 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

The Alabama Medicaid Agency is responsible for mandating and enforcing the Title XIX Medical Assistance State Plan. The Alabama Medicaid Agency

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contracts with a fiscal agent to process and pay all claims by providers of medical care, services, and equipment authorized under the provisions of the Alabama Title XIX State Plan. The present fiscal agent contract is with Gainwell Technologies (Gainwell), PO Box 244032, Montgomery, AL 36124-4032. Their toll free telephone is 800-688-7989.

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

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

7.2.2 Claims Denials and the Appeals Process

Denials fall into one of three categories which are:

- Outdated Claims
- Medical Utilization (Example: Denials for exceeding maximum units, separate and distinct service provided that is being billed, etc.)
- National Correct Coding Initiative (NCCI)

The process for appealing denials for each of the categories is as follows:

Outdated Claim Denial Appeal Process

Step 1: Administrative Review

When a denial of payment is received for an outdated claim, the provider may request an Administrative Review of the claim. A request for an administrative review **must be received by the Medicaid Agency within 60 days of the time the claim became outdated.** The request must be received on a Request for Administrative Review of Outdated Medicaid Claims (form 404) which is available in Appendix E of the Provider Manual. In addition the request should include the following:

- A clean claim printed on a red line drop out form (CMS Form UB04 or 1500)
- Supporting documentation such as a remittance advices or any correspondence with Gainwell or the Agency.

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

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

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

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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. Please note if the claim was denied for timely filing as a result of the Administrative Review, the provider does not have a basis to request a Fair Hearing.

Medical Utilization Denial Appeal Process

Step 1: Redetermination Request

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

When a claim is denied for Medical Utilization, the provider may request a redetermination as long as the claim is within the timely filing limit. A *redetermination* is an examination of a claim and operative notes/medical justification by Gainwell personnel. The request for Redetermination must include:

- Completed Medical Utilization Redetermination Review Form 401
- Corrected, completed, red drop out, clean claim (applicable CMS form UBO4 or 1500) for only the procedure codes that denied. The corrected claim must include the applicable modifier(s)
- All relevant RAs and previous correspondence with Gainwell or the Agency
- Medical documentation (Operative Notes, Medical Justification, Medical Records, Supportive reports, etc.)

Documentation must be sent in on single sided paper, double sided copies are not allowed and will be returned without being processed.

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

Gainwell Technologies
Request for Medical Utilization Redetermination
PO Box 244032
Montgomery, AL 36124-4034

Gainwell will normally issue a decision via the remittance advice within 90 days of receipt of the redetermination request. A letter will NOT be sent to the provider.

Step 2: Medical Utilization Administrative Review

When the redetermination request results in a denial by Gainwell, the provider may request an *administrative review* of the claim as long as the claim is within the timely filing limit. The request should clearly explain why the provider

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disagrees with the redetermination denial. The request for an administrative review must include:

- Completed Medical Utilization Administrative Review Form 402
- Corrected Paper Claim for ONLY the procedure codes that denied. The corrected claim must include the applicable modifier(s)
- Copy of previous request for redetermination correspondence sent to Gainwell
- Copies of all relevant remittances advices or Gainwell's redetermination denial notification
- Medical documentation (Operative Notes, Medical Justification, Medical Records, Supportive reports, etc.)

Documentation must be sent in on single sided paper, double sided copies are not allowed and will be returned without being processed.

Send the request for a Medical Utilization Administrative Review along with all supporting documentation to:

Administrative Review – Medical Utilization
Alabama Medicaid Agency
Attn: Fiscal Agent Policy and System Management
501 Dexter Avenue
P. O. Box 5624
Montgomery, AL 36103-5624

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

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

Step 3: Informal Conference (Optional)

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

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

Step 4: Fair Hearing

When the administrative review does not resolve the issue, the provider has the option to request a fair hearing. A written request must be received within 60 days of the date of the administrative review decision. The request must

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identify any new or supplemental documentation. Send the written request for a fair hearing to:

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

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.

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.

NCCI Denial Appeal Process

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

The use of applicable modifiers is critical in successful implementation of the NCCI procedure to procedure edits. Once a claim or line item on the claim has been denied for an NCCI procedure to procedure edit, then the claim **cannot** be adjusted by the provider.

If a claim is denied for an NCCI Medically Unlikely Edit (MUE), the provider can resubmit the claim electronically with the correct units as long as the units are equal to or lesser than the NCCI MUE edit allows. If the units are more than the NCCI MUE edit allows, then an appeal must be requested.

NCCI procedure to procedure edits are coding edits, and are based on coding principles. The Medicaid NCCI Coding is available on the CMS NCCI website at: *https://www.medicaid.gov/medicaid/program-integrity/ncci/index.html*.

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

Step 1: Redetermination Request

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

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

- Completed NCCI Redetermination Review form

  https://medicaid.alabama.gov/documents/9.0_Resources/9.4_Forms_Library/9.4.2_Billing_Forms/9.4.2_Gainwell_NCCI_Redetermination_Request_12-7-20.pdf
- Corrected, completed, red drop out, clean claim (applicable CMS form UB04 or 1500) for only the procedure codes that denied for NCCI. The corrected claim must include the applicable modifier(s)
- All relevant RAs and previous correspondence with Gainwell or the Agency
- Medical documentation (Operative Notes, Medical Justification, Medical Records, Supportive reports, etc.)

Documentation must be sent in on single sided paper, double sided copies are not allowed and will be returned without being processed.

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

Gainwell Technologies
Request for NCCI Redetermination
PO Box 244032
Montgomery, AL 36124-4034

Gainwell will normally issue a decision via the remittance advice within 90 days of receipt of the redetermination request. A letter will NOT be sent to the provider.

The ICN region for the redetermination request will begin with a “91”. For example: 9111082123456

Step 2: NCCI Administrative Review

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

- Completed Form 403 - Request for National Correct Coding Initiative (NCCI) Administrative Review

  http://www.medicaid.alabama.gov/content/9.0_Resources/9.4_Forms_Library/9.4.2_Billing_Forms.aspx
- Corrected Paper Claim for ONLY the procedure codes that denied for NCCI. The corrected claim must include the applicable modifier(s)
- Copy of previous request for redetermination correspondence sent to Gainwell
- Copies of all relevant remittances advices or Gainwell’s redetermination denial notification

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- Medical documentation (Operative Notes, Medical Justification, Medical Records, Supportive reports, etc.)

Documentation must be sent in on single sided paper, double sided copies are not allowed and will be returned without being processed.

Send the request for an NCCI Administrative Review along with all supporting documentation to:

NCCI Administrative Review
Alabama Medicaid Agency
Fiscal Agent Policy and Systems Support
501 Dexter Avenue
P. O. Box 5624
Montgomery, AL 36103-5624

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

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

Step 3: Informal Conference (Optional)

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

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

Step 4: Fair Hearing

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

Alabama Medicaid Agency
Attn: Office of General Counsel
501 Dexter Avenue
P. O. Box 5624
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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.

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.

7.3 Medicare/Medicaid Fraud and Abuse Policy

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

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

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

7.3.1 Providers Must Screen for Excluded Individuals

The HHS Office of Inspector General (HHS-OIG) excludes individuals and entities from participation in Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP), and all Federal health care programs (as defined in section 1128B(f) of the Social Security Act (the Act)) based on the authority contained in various sections of the Act, including sections 1128, 1128A, and 1156. In addition, the Alabama Medicaid Agency also excludes individuals and entities from participation in the Medicaid program under its own authority as specified in 42 CFR Part 1002.

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When the HHS-OIG has excluded a provider, Federal health care programs (including Medicaid and SCHIP programs) are generally prohibited from paying for any items or services furnished, ordered, or prescribed by excluded individuals or entities. (Section 1903(i) (2) of the Act; and 42 CFR section 1001.1901(b)) Also, when the Medicaid Agency has excluded a provider, the Medicaid Agency is prohibited from paying for any items or services furnished, ordered, or prescribed by excluded individuals or entities. (42 CFR section 1002.211) This payment ban applies to any items or services reimbursable under a Medicaid program that are furnished by an excluded individual or entity, and extends to:

- All methods of reimbursement, whether payment results from itemized claims, cost reports, fee schedules, or a prospective payment system;
- Payment for administrative and management services not directly related to patient care, but that are a necessary component of providing items and services to Medicaid recipients, when those payments are reported on a cost report or are otherwise payable by the Medicaid program; and
- Payment to cover an excluded individual's salary, expenses or fringe benefits, regardless of whether they provide direct patient care, when those payments are reported on a cost report or are otherwise payable by the Medicaid program.

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

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

- Services performed by excluded nurses, technicians, or other excluded individuals who work for a hospital, nursing home, home health agency or physician practice, where such services are related to administrative duties, preparation of surgical trays or review of treatment plans if such services are reimbursed directly or indirectly (such as through a pay per service or a bundled payment) by a Medicaid program, even if the individuals do not furnish direct care to Medicaid recipients;
- Services performed by excluded pharmacists or other excluded individuals who input prescription information for pharmacy billing or who are involved in any way in filling prescriptions for drugs reimbursed, directly or indirectly, by a Medicaid program;
- Services performed by excluded ambulance drivers, dispatchers and other employees involved in providing transportation reimbursed by a Medicaid program, to hospital patients or nursing home residents;
- Services performed for program recipients by excluded individuals who sell, deliver or refill orders for medical devices or equipment being reimbursed by a Medicaid program;

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- Services performed by excluded social workers who are employed by health care entities to provide services to Medicaid recipients, and whose services are reimbursed, directly or indirectly, by a Medicaid program;
- Services performed by an excluded administrator, billing agent, accountant, claims processor or utilization reviewer that are related to and reimbursed, directly or indirectly, by a Medicaid program;
- Items or services provided to a Medicaid recipient by an excluded individual who works for an entity that has a contractual agreement with, and is paid by, a Medicaid program; and
- Items or equipment sold by an excluded manufacturer or supplier, used in the care or treatment of recipients and reimbursed, directly or indirectly, by a Medicaid program.

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

- Screen all employees and contractors to determine whether any of them have been excluded by searching the exclusion list located on the Alabama Medicaid Agency's website. All providers must check the list prior to hiring staff to ensure potential staff has not been excluded from participation in the program. All providers must check the list again monthly to ensure existing staff have not been excluded from participation in the program since the last search.
- Screen all employees and contractors by searching the HHS-OIG website by the names of any individual or entity to determine if any of them have been excluded from participation in the program. All providers must search the HHS-OIG website prior to hiring staff and again monthly to capture exclusions and reinstatements that have occurred since the last search.
- Screen all employees and contractors by searching the SAM (System for Award Management) website, formerly the EPLS (Excluded Parties List System), to determine if any of them are excluded from participation in the program. All providers must search the SAM website prior to hiring and again monthly.
- Providers must immediately report to Medicaid any exclusion information discovered.

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

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Where Providers Can Look for Excluded Parties

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

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

The SAM website also contains information on individuals and entities that have been excluded from participating in federal and state healthcare programs. This website is located at https://www.sam.gov and is searchable by searching for individual or entity name, SSN or TIN, and also includes advanced search options including exclusion type, exclusion program, city, and state, etc.

7.4 Appeals

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

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7.5 Refunds

Medicaid Refunds

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

Medicaid Adjustments

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

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

NOTE:

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

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

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

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

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

7.6 Self-Audits

Alabama Medicaid Agency (Medicaid) has an established self-audit (referred to by CMS as a self-disclosure) process to enable Medicaid providers to self-report actual violations of Medicaid policy and return, to Medicaid, any identified overpayments associated with the policy violations. A self-audit is an audit, examination, review or other inspection performed by and within a provider's practice or business. A self-audit can both prevent and reduce improper payments, ensure that claims submitted are true and accurate, minimize billing mistakes as well as enhance patient care.

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Providers are encouraged to conduct audits of their billing practices at least once a year. These audits would identify any billing practices and/or errors that may be in violation of Medicaid's policies. The identified overpayment must be returned to Medicaid no later than 60 days after the date on which the overpayment was identified.

Notification of Intent
When providers conduct self-audits and determine an overpayment, the provider must complete the *Provider Self-Audit Notification of Intent* Form and return it to the email address listed at the top of the form (providerselfaudit@medicaid.alabama.gov). The Control Number (listed on the Form) will be provided by Medicaid after the completed form is submitted to Medicaid by the provider or its designee. This form is located at the following link:

https://medicaid.alabama.gov/documents/9.0_Resources/9.4_Forms_Library/9.4.2_Billing_Forms/9.4.2_Form_600_Provider_Self_Audit_Instructions_12-31-21.pdf

Required Elements of a Complete Self-Audit Report

Below are the self-audit documents to send to Medicaid:

1. A cover letter on your business letterhead which summarizes:
    - Business Name
    - Billing NPI number
    - Overview of the issues identifies
    - Time period covered by the review
    - Type of sampling (100%, random, etc.)
    - Actions for what has been implemented to assure these errors do not reoccur
    - Error percentage rate
    - Copy of the refund check OR withhold from checkwrite(s) instructions
    - Point of contact name and telephone number and/or email address to discuss the self-audit

2. Audit findings in a Microsoft Excel® electronic spreadsheet at a minimum must include the items below:
    - Recipient name
    - Medicaid ID number
    - Date of service
    - Procedure code found billed in error
    - ICN
    - NPI number
    - Amount billed
    - Amount paid
    - Paid date
    - Refund amount to Medicaid
    - Reason for error

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3. Payment is expected to be attached to the self-audit report. Acceptance of payment does not constitute agreement as to the amount of loss suffered by the Alabama Medicaid Program

Verification

Following the receipt of the provider's self-audit report, Alabama Medicaid will verify the disclosed information. The timeframe for Alabama Medicaid's verification effort will depend, in large part, upon the quality and thoroughness of the submissions received. Matters uncovered during the verification process, which are outside of the scope of the disclosure being verified, may be treated as new matters outside the self-audit process. Alabama Medicaid may request additional information to aid in the verification of the provider's submission.

Payments

Payment of the identified overpayment is expected to be received by Medicaid at the same time as the provider's self-audit report. Failure to submit the overpayment in full with the report will result in Medicaid notifying its fiscal agent to deduct the total identified overpayment amount from future checkwrite(s).

Instructions for sending payment of the identified overpayment, are included in the above mentioned *Provider Self-Audit Instructions* document available at the following link:

https://medicaid.alabama.gov/documents/9.0_Resources/9.4_Forms_Library/9.4.2_Billing_Forms/9.4.2_Form_600_Provider_Self_Audit_Instructions_12-31-21.pdf

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8 Ambulance (Ground & Air)

Medicaid covers transportation costs to and from medical care facilities for eligible recipients. The following services include:

- 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

Gainwell 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

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

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

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

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National Provider Identifier, Type, and Specialty

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

NOTE:

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

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

Valid specialties for transportation providers include the following:

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

Enrollment Policy for Transportation Providers

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

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

Change of Ownership (CHOW) and Closures

Medicaid will mirror Medicare's Change of Ownership (CHOW) policy. Refer to Chapter 19, Hospital for additional information on Change of Ownership.

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. Refer to Chapter 7, Understanding Your Rights and Responsibilities as a Provider, for general criteria on Medical Necessity/ Medically Necessary Care.

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

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

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

Reasonableness of the Ambulance Trip

Payment is made according to the medically necessary services actually furnished. That is, payment is based on the level of service furnished (provided they were medically necessary), not simply on the vehicle used. Even if a local government requires an ALS response for all calls, payment under the fee schedule is made only for the level of service furnished, and then only when the service is medically necessary.

Medical Necessity

Medical Necessity is established when the recipient's condition is such that use of any other method of transportation is contraindicated. In other words, the recipient could not be transported by any other means of transportation without endangering their health. If the recipient could be transported by means other than ambulance, e.g. wheelchair van, car, taxi etc. without endangering the recipient's health, then medical necessity does not exist. It does not make a difference whether or not the other means of transportation are actually available in the locality.

Medical necessity is determined based on the conditions of the recipient at the time of service. Carriers are instructed to presume the requirement is met if the recipient:

- was transported in an emergency situation, e.g. as a result of an accident, injury or acute illness, or
- needed to be restrained to prevent injury to the patient or others, or
- was unconscious or in shock, or
- required oxygen or other emergency treatment on the way to his destination, or
- exhibited signs and symptoms of acute respiratory distress or cardiac distress, e.g. shortness of breath, chest pain, or
- had to remain immobile because of a fracture that had not been set or the possibility of a fracture, or
- exhibited signs and symptoms of a possible acute stroke, or
- was experiencing a severe hemorrhage, or
- was bed confined before and after the ambulance trip, or
- could only be moved by stretcher.

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NOTE:

If the condition was one of the last two (2) listed above, i.e. bed confided or could only be moved by a stretcher, it is prudent to document the reasons why the recipient was bed confined or could only be moved by stretcher. Also, while “bed confined” is still listed as CMS in their manual as “before and after”, they have clarified it refers to the time of transport.

Bed Confined

A national definition for bed confined has been established in the Regulations at 42 CFR 410.40. A beneficiary will be considered bed confined only if they are:

- unable to get up from bed without assistance, and
- unable to ambulate, and
- unable to sit in a chair or wheelchair.

8.2.1 Non-Emergency Transportation (NET) Program Services

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

All payments for NET services require authorization.

8.2.2 Non-Emergency Ambulance Services

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

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

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8.2.3 Emergency Ambulance Services

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

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

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

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

8.2.4 Air Transportation Services

Medicaid reimburses air transportation services for all Medicaid recipients with prior authorization approval only. Air transportation for adults (recipients over 21 years of age) is reimbursed at the ground ambulance rate.

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

Medicaid requires that the recipient be taken to the nearest hospital that has appropriate facilities, physicians, or physician specialists needed to treat the recipient’s condition. The hospital must have a bed or specialized treatment unit immediately available. If the recipient is not taken to the nearest appropriate hospital, payment will be limited to the rate for the distance from the pick-up point to the nearest appropriate hospital. Medicaid does not consider trips of less than 75 loaded miles to be appropriate unless extreme, extenuating circumstances are present and documented. If more than one recipient is transferred in the same air transport trip, only one recipients transport will be reimbursed.

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

8.3 Prior Authorization Requirements

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

In the case of Retroactive Eligibility, the provider has 90 days after the date on which the award of retroactive eligibility was made to submit their request for prior approval. It is the provider’s responsibility to submit a copy of the retroactive eligibility determination along with the prior approval request to Medicaid.

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NOTE:

Prior Authorization requests may be submitted to Medicaid's Fiscal Agent via FAX or regular mail. Providers are instructed to follow-up with the fiscal agent within four to five days to ensure the request was received, and again in two weeks, if no reply has been received.

NOTE:

"Clean" Prior Authorization (PA) requests must be received by our Fiscal Agent (Gainwell) within thirty (30) business days from the date of service. A "Clean" PA request is one where valid information is submitted on both the provider and the recipient regarding services that were rendered on a specific date of service and without any RTPs (Return To Provider) which would create a delay for your request.

Prior Authorization for Non-Emergency Transportation

All non-emergency ambulance services 100 miles or greater one way requires prior authorization. However, the provider has thirty (30) business days from the date the service was rendered to obtain the prior authorization (PA).

When submitting Prior Authorization requests for non-emergency ground ambulance transport >100 miles, the following condition codes are the only ones recognized by Alabama Medicaid:

Condition Code	***Description***
02	Bed confined before the ambulance service
04	Moved by stretcher
05	Unconscious or in shock
07	Physically restrained
08	Visible hemorrhaging

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Prior Authorization for Air Transportation

All payments for air transportation services require authorization from Medicaid.

The following steps must be followed for air ambulance providers to receive reimbursement:

1. Medicaid's Fiscal Agent must receive authorization requests no later than thirty business days after the service was rendered. **Please include the following:**
   - Air versus ground time and/or distance
   - Age of recipient
   - Diagnosis and severity of condition
   - Any other pertinent medical data as deemed necessary to document air transportation
2. The provider must supply the above documentation for any service requiring immediate transportation. The documentation must also include a copy of the flight record, progress notes from institution that requested air transport, and documentation of reason why ground transport is not feasible.
3. Medicaid's Fiscal Agent assigns a prior authorization number and forwards the request to the Medicaid Prior Approval Program for review.
4. The Prior Approval Program reviews the request and forwards it to the contracted Medicaid designee reviewer for approval/denial.
5. If Medicaid or the contracted Medicaid designee reviewer determines that air transportation is not medically necessary and the criteria are met for ground transportation, the request is approved at the emergency ground rate. The provider will bill authorized amount and be reimbursed at the emergency ground rate.
6. Providers who are dissatisfied with the decision of Medicaid or the contracted Medicaid designee reviewer must request an informal review of medical information. The request must be in writing and received by Medicaid within thirty days of the modified approval letter. If additional information is not submitted for review, the decision will be final and no further review will be available.
7. Provider is instructed to submit claim to Medicaid's Fiscal Agent for payment with the assigned prior authorization number.
8. Prior authorization requests will be accepted from newly enrolled providers for dates retroactive to the first day of the month preceding the month of the effective date provider is added to the Medicaid system.
9. In the event an air transport provider is unable to verify a recipient's eligibility prior to or at the time of the transport due to the patient being unconscious or disoriented and no family member being available, the provider's prior authorization request will be reviewed on a case by case basis.
10. The request must include documentation detailing the reason eligibility was not verified prior to transport.

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8.4 Cost Sharing (Copayment)

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

8.5 Billing Recipients

By filing a claim with the Medicaid Program, a provider is agreeing to accept assignment and by accepting assignment, the provider agrees to accept the Medicaid reimbursement, plus any cost-sharing amount (copay) to be paid by the recipient, as payment in full for those services covered under the Medicaid Program. The Medicaid recipient, or others on his behalf, must not be billed for the amount above that, if any, which is paid on an allowed service.

8.6 Completing a Claim

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

8.6.1 Diagnosis Codes

The *International Classification of Diseases - 10th Revision - Clinical Modification* (ICD-10-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, AMA Plaza 330 North Wabash Ave, Suite 39300 Chicago, IL 60611-5885, or 1-800-621-8335.

NOTE:

ICD-9 or ICD 10 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.

Air transportation providers should only bill diagnosis code used on the prior authorization

Refer to Appendix R: Ambulance (Ground and Air) Diagnosis Codes for the appropriate ICD-9 and ICD-10 diagnosis codes to use on claims.

8.6.2 Procedure Codes and Modifiers

Please refer to the Ambulance Fee Schedule for procedure codes and rates. The (837) Institutional electronic claim and the paper claim have been modified to accept up to four Procedure Code Modifiers.

Ambulance services billed will be commensurate with services actually performed. Services rendered are independent of the type of call received or the type staff / equipped ambulance service responding.

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Procedure Codes for Basic Life Support (BLS) Services

Basic Life Support Service (BLS) is an ambulance service which includes equipment and staff to render basic services such as control of bleeding, splinting fractures, treating shock, performing cardiopulmonary resuscitation (CPR), delivery of babies, use of horizontal immobilizers, restraints for combative recipients, and use of gauze pads/bandages.

Procedure Codes for Advanced Life Support (ALS) Services

An ALS ambulance has similar equipment, crew, and certification requirements under Medicare as a basic ambulance, except the ALS ambulance has complex specialized life-sustaining equipment. It is ordinarily equipped for radio-telephone contact with a hospital or physician. A typical ALS ambulance may be a mobile coronary care unit or other vehicle appropriately equipped and staffed by personnel authorized to initiate and administer IV fluids, establish and maintain a recipient's airway, defibrillate the heart, relieve pneumothorax conditions, administer cardiopulmonary resuscitation (CPR), provide anti-shock therapy ,administer life sustaining drugs, venous blood draws, cardiac monitoring (EKG), administer pacing nebulizer and perform other advanced life support procedures or services to recipients during the transport. Documentation must support need for ALS services.

Services Not Covered by Medicare That Are Covered by Medicaid

- Some non-emergency ambulance services are non-covered by Medicare but are covered by Medicaid if billed in conjunction with the modifiers below. These claims should be filed on a medical claim electronically.
- Modifiers DD, DG, DJ, DN, DP, DR, ED, GD, GP,HD, HP, ND, JP, NP, PD, PE, PG, PH, PJ, PN, PP, PR, RD, or RP
- A0422, A0225, A0382

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

First Modifier

The first place alpha code is the origin; the second place alpha code is the destination. **The valid origin/destination modifiers and their explanations are listed below:**

Modifier	***Description***
D	Diagnosis or therapeutic site other than P or H when these are used as origin codes
E	Residential, domiciliary, custodial facility (other than 1819 facility)

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Modifier	*Description*
G	Hospital-based dialysis facility (hospital or hospital related)
H	Hospital
I	Site of transfer (e.g., airport or helicopter pad) between modes of ambulance transport
J	Non-hospital based dialysis facility
N	Skilled nursing facility (SNF) (1819 facility)
P	Physician's office (includes HMO non-hospital facility, clinic, etc.) (Note: Bed-bound recipients only, NET Program prior authorization required)
R	Residence
S	Scene of accident or acute event

For example, when a recipient is picked up at the residence (origin code R) and taken to the hospital (destination code H) for an ALS emergency transport (procedure code A0427), the claim is coded as **A0427RH.**

The following are all of the valid combinations for the first modifier fields:

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

NOTE:

For ground ambulance transport from a residence to an airport or helicopter site the ground provider should use the modifier combination “SI” since the reason for transport would be an accident or “acute event”.

Second Modifier (These are not required by Medicaid)

Modifier	*Description*
2A	Accidental injury home/nursing home
3A	Accidental injury
4A	Recipient in shock
6A	Transported by stretcher
8A	Hospital lacks facility (recipient admitted to second hospital)
9A	Rectal bleeding
5B	Dead on arrival (DOA) at hospital
6B	Died en route to hospital

Repeat Trip

Modifier TS (Follow up Service) is used in the second modifier position to indicate a repeat trip for the same recipient on the same day.

When a recipient is picked up at a hospital (origin code H), taken to another hospital (destination code H), and returned to the original hospital, bill the procedure code with a TS modifier for Follow-up Service.

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8.6.3 Place of Service Codes

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

POS	*Description*
41	Ambulance – Land
42	Ambulance – Air or Water

8.6.4 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to claims with third party denials.

NOTE:

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

Refer to Chapter 5, Section 5.8, Required Attachments, for more information on attachments.

8.7 For More Information

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

Resource	Where to Find it
CMS-1500 Claim Filing Instructions	Chapter 5
Medical Medicaid/Medicare-related Claim Filing Instructions	Chapter 5
Medical Necessity/Medically Necessary Care	Chapter 7
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 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

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

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

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

National Provider Identifier, Type, and Specialty

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

NOTE:

All ten characters are required when filing a claim effective.

ASC Providers are assigned a provider type of 02 (ASC). Valid specialties for ASC providers include the following:

- Ambulatory Surgical Center (020)
- Lithotripsy (520)

Enrollment Policy for Ambulatory Surgical Center Providers

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

- Certification for participation in the Title XVIII Medicare Program
- Approval by the appropriate licensing authorities

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- 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)

Change of Ownership (CHOW) and Closures

Medicaid will mirror Medicare's Change of Ownership (CHOW) policy.

Refer to Chapter 19, Hospital for additional information on Change of Ownership.

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. Refer to Chapter 7, Understanding Your Rights and Responsibilities as a Provider, for general criteria on Medical Necessity/ Medically Necessary Care.

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

Rates of reimbursement for ASC services include, but are not limited to:

- Nursing, technician and related services
- Use of an ambulatory surgical center
- Lab and x-ray, drugs, biologicals, surgical dressings, splints, casts, appliances, and equipment directly related to the provision of the surgical procedure
- Diagnostic or therapeutic services or items directly related to the provision of a surgical procedure
- Administrative, record keeping, and housekeeping items and services
- Materials for anesthesia

NOTE:

Outpatient dental care (procedure code D9420) must be prior approved and is covered only for recipients under the age of 21. The dentist is responsible for obtaining prior approval from the Alabama Medicaid Agency Dental Program at (334) 242-5472. Dental services provided to SOBRA adult females are non-covered.

ASC services do not include items and services for which payment may be made under other provisions. Ambulatory surgical center services do not include:

- Physician services
- Lab and x-ray not directly related to the surgical procedure
- Diagnostic procedures (other than those directly related to performance of the surgical procedure)
- Prosthetic devices (except intraocular lens implant)
- Ambulance services
- Leg, arm, back, and neck braces
- Artificial limbs
- Durable medical equipment for use in the patient's home

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ASC services are reimbursed by means of a predetermined fee established by Medicaid. All ASC procedures will be reimbursed at the lesser of the predetermined rate for the procedure or the provider's submitted charge less the copay amount.

NOTE:

Ambulatory surgical center services are limited to three encounters each calendar year.

Medicaid pays for a surgical procedure performed on an outpatient basis for a Medicaid recipient only if the procedure is on the approved surgical list found in Appendix I.

Covered Surgical Procedures

Covered surgical procedures are procedures that meet the following criteria:

- Surgical procedures commonly performed on an inpatient basis in hospitals but may be safely performed in an ambulatory surgical center setting
- Surgical procedures limited to those requiring a dedicated operating room and generally requiring a post-operative recovery room or short-term (not overnight) convalescent room
- Surgical procedures not otherwise excluded under 42 C.F.R. § 416.65 or other regulatory requirement
- Procedure codes within the range of 10000-69XXX

Providers should refer to the Ambulatory Surgical Center fee schedule before scheduling outpatient surgeries since some procedures are restricted to recipients under age 20 and others may require prior authorization.

Ambulatory Surgical Center Transfer Procedures

The ambulatory surgical centers must have an effective procedure for the immediate transfer to a hospital of recipients requiring emergency medical care beyond the capabilities of the center. The hospital will have a provider contract with Medicaid. The center must have a written transfer agreement with said hospital, and each physician performing surgery in the center must have admitting privileges at said hospital. Changes in this submitted information will be made available to the Gainwell 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.

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If more than one covered surgical procedure is furnished to a Medicaid recipient in a single operative session, Medicaid pays the lesser of either the submitted charges or the full amount for the procedure with the higher predetermined rate less the copay amount. Other covered surgical procedures furnished in the same session will be reimbursed at the lesser of the submitted charges or at 50 percent of the predetermined rate for each of the other procedures, whichever is lowest.

Payment Adjustment for Provider Preventable Conditions (PPC's)

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

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

It is the responsibility of the provider to identify and report any PPC and not seek payment from Medicaid for any additional expenses incurred as a result of the PPC.

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

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

- The PPC must be reasonable preventable as determined by a root cause analysis or some other means.
- The PPC must be within the control of the provider.
- The PPC must be clearly and unambiguously the results of a preventable mistake made and provider procedures not followed, and not an event that could otherwise occur.
- The PPC must result in significant harm. The OPPC's for considerations should be limited to those that yield a serious adverse result. Serious adverse result is defined as one that results in death, a serious disability or a substantial increase in the duration and/or complexity of care that is well beyond the norm for treatment of the presenting condition. A serious disability is defined as a major loss of function that endures for more than 30 days, is not present at the time services were sought and is not related to the presenting condition.
- Any process for identifying non-payable events must actively incorporate some element of case-by-case review and determination. While the source and cause of some adverse events may be clear, most would require further investigation and internal root cause analysis to determine the cause of the serious preventable event and to assign ultimate accountability.

OPPCs must be reported via encrypted emailing of the required information to: AdverseEvents@medicaid.alabama.gov. Providers that do not currently have a password for the Adverse Event reporting may request one by contacting Solomon Williams at Solomon.williams@medicaid.alabama.gov or via phone at 334-353-3206.

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Reportable OPPCs include but are not limited to:

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

The following information is required for reporting:

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

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

9.3 Prior Authorization and Referral Requirements

Certain procedures require prior authorization. Please refer to the ASC Procedures List in Appendix I. A "Y" in the PA column on the list indicates surgical procedures that require prior approval. Payment will not be made for these procedures unless authorized prior to the service being rendered.

When filing claims for recipients enrolled in the Alabama Coordinated Health Network (ACHN) Program, refer to Chapter 40, to determine whether your services require a referral from the Primary Care Physician (PCP).All requests for prior approval must document medical necessity and be signed by the physician. Requests should be sent to Gainwell, Attention Prior Authorization, P.O. Box 244032, Montgomery, Alabama 36124-4032.

The prior authorization number issued must be listed on the UB-04 claim form when billing for the prior authorization service.

NOTE:

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

9.3.1 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 **$3.90** per encounter. The copayment does not apply to services provided for pregnant women, nursing facility residents, recipients less than 18 years of age, emergencies, family

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planning, and crossovers. Native American Indians that present an "active user letter" issued by Indian health Services (IHS) will be exempt from the Medicaid required copayment.

9.5 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

ASC providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When filing a claim on paper, a UB-04 claim form is required. Medicare-related claims must be filed using the Medical Medicaid/Medicare Related Claim Form.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

For straight Medicaid claims, ASCs should bill Medicaid on the UB-04 claim form. Medicare-related claims should be filed using the Medical Medicaid/Medicare Related Claim Form.

9.5.1 Time Limit for Filing Claims

Medicaid requires all claims for ambulatory surgical center providers to be filed within one year of the date of service. Refer to Section 5.1.4, Filing Limits, for more information regarding timely filing limits and exceptions.

9.5.2 Diagnosis Codes

The *International Classification of Diseases - 10th Revision - Clinical Modification* (ICD-10-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the
American Medical Association, AMA Plaza 330 North Wabash Ave, Suite 39300 Chicago, IL 60611-5885, or 1-800-621-8335.

NOTE:

ICD-9 codes should be used for claims submitted with dates of service prior to or equal to 09/30/2015.

ICD-10 codes should be used for claims submitted with dates of service on/after 10/01/2015

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NOTE:

ICD-9 or ICD-10 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits).

9.5.3 Procedure Codes and Modifiers

ASC providers use the Current Procedural Terminology (CPT) coding system. The CPT manual lists most required procedure codes. This manual may be obtained by contacting the Order Department, American Medical Association, AMA Plaza 330 North Wabash Ave, Suite 39300 Chicago, IL 60611-5885, or 1-800-621-8335. The (837) Institutional electronic claim and the paper claim have been modified to accept up to four procedure code modifiers.

Only procedures listed in the ASC Procedures List are reimbursable in the ambulatory surgical setting. The list of covered outpatient procedures is located in Appendix I.

NOTE:

Procedures not listed on the ASC Procedures List may be covered under special circumstances. Approval must be obtained prior to the surgery. Refer to Section 9.3, Prior Authorization and Referral Requirements, for more information. Prior to providing services, providers should inform recipients of their responsibilities for payment of services not covered by Medicaid.

9.5.4 Place of Service Codes

Place of service codes do not apply when filing the UB-04 claim form.

9.5.5 Required Attachments

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

- Claims with Third Party Denials

NOTE:

When an attachment is required, a hard copy UB-04 claim form must be submitted.

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

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9.6 For More Information

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

Resource	Where to Find It
UB-04 Claim Filing Instructions	Section 5.3
Medical Medicaid/Medicare-related Claim Filing Instructions	Section 5.6.1
Sterilization/Hysterectomy/Abortion Requirements	Section 5.7
Medical Necessity/ Medically Necessary Care	Section 7.1.1
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N
ASC Procedures List	Appendix I

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10 Audiology/Hearing Services

Audiological function tests and hearing aids are limited to Medicaid recipients who are eligible for treatment under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program. These services do not require an EPSDT referral. See chapter 40 for Alabama Coordinated Health Network (ACHN) PCP referral requirements. Hearing aids are provided through hearing aid dealers who are contracted to participate in the Alabama Medicaid Hearing Aid Program.

An eligible recipient with hearing problems may be referred to a private physician or to a Children's Specialty Clinic for medical evaluation.

The policy provisions for audiology and hearing services providers can be found in the *Alabama Medicaid Agency Administrative Code,* Chapter 19.

10.1 Enrollment

Medicaid's Fiscal Agent enrolls hearing services providers and issues provider contracts to applicants who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code*, and the *Alabama Medicaid Provider Manual.*

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

Federal requirements mandate providers re-validate periodically with the Alabama Medicaid program. Providers will receive notification for re-validation. Failure to provide the appropriate information to complete re-validation application will result in an end date of the provider file. When this occurs, the provider will have to submit a new application for enrollment.

Only in-state and bordering out-of-state (within 30 miles of the Alabama state line) audiology and hearing aid providers who meet enrollment requirements are eligible to participate in the Alabama Medicaid program.

National Provider Identifier, Type, and Specialty

A provider who contracts with Alabama Medicaid as an Audiology/hearing provider is added to the Medicaid system with the National Provider Identifiers provided at the time application is made. Appropriate provider specialty codes are assigned to enable the provider to submit requests and receive reimbursements for hearing-related claims.

NOTE:
The 10-digit NPI is required when filing a claim.

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Providers are assigned the following valid provider type and specialty:

- Audiology 20/200
- Hearing Aid Dealer 22/220

Enrollment Policy for Audiology Providers

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

Alabama Medicaid's Fiscal Agent responsible for enrollment of audiologists. Licensed audiologists desiring to participate in the Alabama Medicaid Program must furnish the following information to Alabama Medicaid's Fiscal Agent 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 State of Alabama Hearing Instrument Dealers Board, 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. Refer to Chapter 7, Understanding Your Rights and Responsibilities as a Provider, for general criteria on Medical Necessity/ Medically Necessary Care. Refer to chapter 4, Obtaining Prior Authorization (PA), for general information on submitting request for PA.

10.2.1 Cochlear Implants, Auditory Brain Stem Implants, Implantantable Bone Anchored Hearing Aids and Soft Band Bone Conduction Hearing Aids

Cochlear Implants (69930)

PA for the preoperative evaluation and the implantation must be requested by a Medicaid-approved *cochlear implant team surgeon,* using the Authorization for Cochlear Implants Form (PHY-96-11). Follow this link to retrieve the form: http://www.medicaid.alabama.gov/content/9.0_Resources/9.4_Forms_Library/9.4.14_Prior_Auth_Forms.aspx

Specialty Code 740 is needed to enroll for Cochlear Implants.

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The Criteria for the Team members is as follows;

1. Surgeon Board certified otolaryngologist
   Completion of Nucleus Pediatric Cochlear Implant Surgeons' Course or show evidence of training during residency.
   Successfully performed previous Pediatric Cochlear Implantations

2. Audiologist Master's degree from an accredited institution
   Certificate of Clinical competence in audiology
   Alabama License in audiology
   Completion of the Cochlear Implant Workshop

3. Speech/Language Pathologist
   Master's degree from an accredited institution
   Certificate of Clinical Competence in Speech/Language Pathology
   Alabama License in Speech/Language Pathology
   Experience in auditory-verbal and total communications methodologies

4. Rehabilitation Specialist-not required as part of the team, but must have available for consultation the following professionals:
   Psychologists
   Social Workers
   Physical Therapists
   Occupational Therapist

Medicaid may reimburse for cochlear implant services for recipients who meet the following criteria:

1. EPSDT referral
2. Chronological age 9 months through 20 years of age
3. Severe to Profound (70 decibels or above) sensorineural hearing loss bilaterally and minimal speech perception under best aided conditions
4. Minimal or no benefit obtained from a hearing (a vibrotacile) aid as demonstrated by failure to improve on age appropriate closed-set work identification task. Appropriate amplification and rehabilitation for a trial period is required to assess the potential for aided benefit. Benefits may be extended to candidates with severe hearing impairment and open-set sentence discrimination that is less than or equal to 30 percent in the best aided conditions.
5. No medical or radiological contraindications, and ontologically stable and free of active middle ear disease prior to cochlear implantation.
6. Families/caregivers and possible candidates well-motivated. Education must be conducted to ensure parental understanding of the benefits and limitations of the device, appropriate expectations, commitment to the development of auditory and verbal skills, dedication to the child's therapeutic program and the ability to adequately care for the external equipment.

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Effective June 1, 2002, Medicaid will reimburse for a personal FM system for use by a cochlear implant recipient when prior authorized by Medicaid and not available by any other source. The replacement of lost or damaged external components (when not covered under the manufacturer's warranty) will be a covered service when prior authorized by Medicaid.

Effective May 1, 2023, Cochlear Implant manufacture's providers can request a PA with the required invoice for their product.

Reimbursements for manufacturer's upgrades will not be made within the first two years following initial implantation.

Prior Authorization (PA) Procedures are as follows:

1. The PA number issued for the cochlear implant must be indicated in the clinical statement.
2. Additional medical documentation supporting medical necessity for repairs to or replacement of minor parts for cochlear external processor (L7510), replacement of the cochlear Implant Processor (L8619) or ancillary accessories, should be attached.

Auditory Brain Stem Implants (ABI) (S2235)

An ABI is covered and requires a PA.

Medicaid may reimburse for ABI services for recipients who meet the following criteria:

1. Must be 12-20 years of age
2. Physician notes must indicate the diagnosis of Neurofibromatosis Type II
3. Medical assessment to ensure candidate is able to tolerate surgery
4. Documentation of anticipatory guidance to child/parents concerning expected outcomes, complications, and possible aural rehabilitation

Implantable Bone Anchored Hearing Aids (BAHA) (69714, 69715, 69717, 69718)

An Osseointegrated Implant (BAHA) is covered and requires a PA.

Medicaid may reimburse for osseointegrated implant services for recipients who meet the following criteria:

1. Must be 5-20 years of age; and
2. Congenital or surgically induced malformations of the external ear canal or middle ear; or
3. Chronic external otitis or otitis media when a conventional hearing aid cannot be worn; or
4. Tumors of the external canal.
5. Must all meet audiologic criteria of: A bone conduction pure-tone average of 65 decibels or better, with no single frequency poorer than 70 decibels (at 1000 and 2000Hz) and speech discrimination score better than 60%.

For Single Sided Deafness (SSD), criteria are as follows:

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1. Must be 5-20 years of age; and
2. Bone conduction of 35-40 dB or better in the contralateral ear.

Auditory Osseointegrated Implant (AOI) (69716, 69719, 69726, 69727)

AOI are hearing devices that use an external receiver/processor that stimulates bone conduction of sound via a titanium prosthesis that is drilled into the bone of the cranium. The AOI delivers sound to the organ of hearing via direct bone conduction. An external sound processor then captures sound and transmits these signals as sound vibrations to the titanium implant.

Medicaid may reimburse for AOI devices for recipients who meet the age requirement and the following criteria:

- Must have an EPSDT referral
- Must be 5-20 years of age; and
- Congenital or surgically induced malformations of the external ear canal or middle ear; or
- Chronic external otitis or otitis media when a conventional hearing aid cannot be worn; or
- Tumors of the external canal and/or tympanic cavity; or
- Dermatitis of the external canal
- Must also meet audiologic criteria of: A bone conduction pure-tone average of 65 decimals or better, with no single frequency poorer than 70 decibels (at 1000 and 2000Hz) and speech discrimination score better than 60%.

For Single Sided Deafness (SSD), criteria are as follows:

- Must be 5-20 years of age; and
- Bone conduction of 35-40 dB or better in the contralateral ear.

Auditory Osseointegrated Implant devices (AOI) requires a PA.

AOI devices integrated implant surgery will only be allowable in a hospital setting and will be reimbursable to physicians. The osseointegrated device will be purchased by the hospital and covered through the hospital's per diem.

If the request is for a replacement sound processor upgrade, specific information regarding the medical necessity of the upgrade, such as the current processor is no longer functional and cannot be replaced with the same model must be provided.

Reimbursement for manufacturer's upgrades will not be made within the first two years following initial implantation. The replacement of a lost or damaged external processor (when not covered under the manufacturer's warranty) will be a covered service when prior authorized.

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Soft Band Bone Conduction Hearing Aid (L8692)

The osseointegrated device, external sound processor, used without osseointegration (soft band device without surgically implanted components) is covered for recipients less than 21 years of age whose moderate to severe bilateral, conductive or mixed hearing loss cannot be effectively restored by conventional air conduction aids or a conventional bone conduction hearing aid.

PA is required for all new soft band bone conduction hearing aids.

Medicaid may reimburse for the soft band hearing aid for recipients who meet the age requirement and the following criteria:

- Congenital or surgically induced malformations of the external ear canal or middle ear that precludes the wearing of a conventional air conduction hearing aid; or
- Chronic external otitis or otitis media with persistent discharge when a conventional hearing aid cannot be worn; or
- Tumors of the external canal and/or tympanic cavity; or
- Dermatitis of the external canal
- Must also meet audiologic criteria of: a bone conduction pure-tone average of 40-50 decibels or better, with no single frequency poorer than 50 decibels (at 1000 and 2000 Hz); *and* speech discrimination score better than 60%, except when the child is too young or developmental delays inhibit the ability to perform the speech discrimination testing
- Documentation submitted will include a copy of the medical clearance from an EENT or Otolaryngologist, a letter of medical necessity from the treating audiologist, and audiology report to include audiogram(s), evaluation, speech and sound tests (if possible to obtain), future surgery information and documentation substantiating that hearing loss cannot be effectively restored by conventional air conduction or conventional bone conduction hearing aids.
- For children deemed inappropriate for surgery, documentation in the form of a physician's statement that describes why the child would not be a candidate for surgical implantation should be submitted
- Additional documentation will be requested as needed

Upgrades to existing, functioning, replaceable sound processors to achieve aesthetic improvement are not medically necessary and will not be covered. If the request for a sound processor, battery replacement, or repair is for spare or back-up equipment for use in emergencies it will not be covered. Replacement and repair are handled under any warranty coverage an item may have. No charge to Medicaid is allowed for replacement and repairs covered under warranty.

Children under the age of 5 yrs. that have unilateral sensorineural hearing loss (single sided deafness) will not be covered. Children with a speech discrimination score at elevated sound pressure levels (SPL) of less than 60% would not benefit from this device.

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10.2.2 Procedure Codes and Modifiers

Audiological function tests must be referred by the attending physician before testing begins. The (837) Professional electronic claim has been modified to accept up to four Procedure Code Modifiers.

Audiology Tests

The following CPT codes represent comprehensive audiological tests that may be performed each calendar year. Additional exams may be performed as needed when medically necessary to diagnose and test hearing defects.

Procedure Code	*Description*
92531	Spontaneous nystagmus, including gaze
92532	Positional nystagmus
92533	Caloric vestibular test, each irrigation (binaural, bithermal stimulation constitutes four tests)
92534	Optokinetic nystagmus
92537	Assessment and recording of balance system during hot and cold irrigation of both ears
92538	Assessment and recording of balance system during irrigation of both ears
92540	Basic Vestibular Evaluation
92541	Spontaneous nystagmus test, including gaze and fixation nystagmus, with recording
92542	Positional nystagmus test, minimum of 4 positions with recording
92544	Optokinetic nystagmus test, bi-directional, foveal 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.

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The following procedure codes are not included in the annual limitations.

Procedure Code	***Description***
92550	Tympanometry & Reflex Thrash
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
92557	Comprehensive audiometry threshold
92558	Evoked otoacoustic emissions; screening, automated analysis.
92560	Bekesy audiometry; screening
92561	Bekesy audiometry; diagnostic
92562	Loudness balance test, alternate binaural or monaural
92563	Tone decay test
92564	Short increment sensitivity index (SISI)
92565	Stenger test, pure tone
92567	Tympanometry
92568	Acoustic reflex testing
92569	Acoustic reflex decay test
92570	Acoustic immittance testing, includes tympanometry
92571	Filtered speech test
92572	Staggered spondaic word test
92573	Lombard test
92575	Sensorineural activity level test
92576	Synthetic sentence identification test
92577	Stenger test, speech
92579	Visual Audiometry
92582	Conditioning play audiometry
92583	Select picture audiometry
92584	Electrocochleography
92585	Brainstem evoked response recording
92586	Auditory evoked potentials for
92587	Evoked otoacoustic emissions
92588	Comprehensive/diagnostic evaluation
92590	Hearing aid examination and selection; monaural
92591	Hearing aid examination and selection; binaural
92592	Hearing aid check; monaural
92593	Hearing aid check; binaural
92594	Electroacoustic evaluation for hearing aid; monaural
92595	Electroacoustic evaluation for hearing aid; binaural
92626	Evaluation of Auditory Rehabilitation Status; first hour
92627	Evaluation of Auditory Rehabilitation Status; each additional 15 mins
92630	Auditory Rehabilitation; pre-lingual hearing loss
92633	Auditory Rehabilitation; post-lingual hearing loss
92640	Diagnostic analysis with programming of auditory brainstem implant, per hour
92651	AEP Hearing Status Deter I & R
92652	AEP Hearing EST MLT FREQ I & R
92653	AEP Neurodiagnostic I & R

Added: 92550 Tympanometry & Reflex Thrash

Added: 92579 Visual Audiometry

Added: 92651 AEP Hearing…Neurodiagnostic I & R

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Cochlear & Auditory Brain Stem Implants (ABI) and BAHA System

Procedure Code	*Description*
69930**	Cochlear Device Implantation (See NOTE below)
69711**	Removal/Repair of temporal bone conduction hearing device
69714**	Implantation, osseointegrated implant, temporal bone, with percutaneous or transcutaneous attachment to external speech processor/cochlear stimulator; without mastoidectomy
69715**	Implantation, osseointegrated implant, temporal bone, with percutaneous or transcutaneous attachment to external speech processor/cochlear stimulator; with mastoidectomy
69716**	Implantation of cochlear stimulating system into skull with magnetic attachment to external speech processor implant external processor / controller replacement.
69717**	Replacement, osseointegrated implant, temporal bone, with percutaneous or transcutaneous attachment to external speech processor/cochlear stimulator; without mastoidectomy
69718**	Replacement, osseointegrated implant, temporal bone, with percutaneous or transcutaneous attachment to external speech processor/cochlear stimulator; with mastoidectomy
69719**	Revision or replacement of cochlear stimulating system into skull with magnetic attachment to external speech processor.
69726**	Removal of cochlear stimulating system from the skull with magnetic attachment through skin to external speech processor.
69727**	Removal of cochlear stimulating system from skull with magnetic attachment to external speech processor
92601	Diagnostic analysis of Cochlear Implant, patient under 7 years of age; with programming.
92602	Diagnostic analysis of Cochlear Implant, patient under 7 years of age; subsequent reprogramming.
92603	Diagnostic analysis of Cochlear Implant, age 7 years or older, with programming.
92604	Diagnostic analysis of Cochlear Implant, age 7 years of age or older; subsequent reprogramming.
92507*	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual
92508	Group, two or more individuals
92626	Evaluation of Auditory Rehabilitation Status; first hour
92627	Evaluation of Auditory Rehabilitation Status; each additional 15 mins
92630*	Auditory Rehabilitation; pre-lingual hearing loss
92633*	Auditory Rehabilitation; post-lingual hearing loss
92640	Diagnostic analysis with programming of auditory brainstem implant, per hour
L7368-RB**	Lithium ion battery charger
L7510-RB**	Repair of prosthetic device, repair or replace minor parts. Will reimburse at invoice price.
L8615**	Headset/headpiece for use with cochlear implant device, replacement
L8616**	Microphone for use with cochlear implant device, replacement
L8617**	Transmitting coil for use with cochlear implant device, replacement
L8618**	Transmitter cable for use with cochlear implant device, replacement
L8619**	Cochlear implant, external speech processor and controller, integrated system replacement
L8621	Zinc air battery for use with cochlear implant device, replacement, each
L8623**	Lithium ion battery for use with cochlear implant device speech processor, other than ear level, replacement, each
L8624**	Lithium ion battery for use with cochlear implant device speech processor, ear level, replacement
L8627**	Cochlear Implant, external speech processor, component, replacement

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Procedure Code	*Description*
L8628**	Cochlear Implant, external controller component, replacement
L8691**	Auditory osseointegrated device, external sound processor, replacement
L8692**	Auditory osseointegrated device, external sound processor, used without osseointegration, body worn, includes headband or other means of external attachment
L9900	Orthotic and prosthetic supply, accessory, and/or service component of another HCPCS L code. Use to bill for BAHA soft band headband replacement.
S2235**	Implantation of Auditory Brain Stem Implant

*Cannot bill 92507 on the same day as 92630 or 92633
**Requires PA
Effective January 1, 2014 and thereafter, procedure codes L7510 and L7368 must be filed with modifier RB

NOTE:

The Cochlear, ABI and BAHA Implantable Devices are purchased at contract prices established by hospital and supplier and covered through the hospital per diem.

Hearing Aid Monaural

Procedure Code	*Description*
V5030	Hearing aid, monaural, body worn, air conduction
V5040	Hearing aid, monaural, body worn, bone conduction
V5050	Hearing aid, monaural, in the ear
V5060	Hearing aid, monaural, behind the ear
V5070	Glasses, air conduction
V5080	Glasses, bone conduction
V5244	Hearing aid, digitally programmable analog, monaural, completely in the ear canal
V5245	Hearing aid, digitally programmable analog, monaural, in the canal
V5246	Hearing aid, digitally programmable analog, monaural, in the ear
V5247	Hearing aid, digitally programmable analog, monaural, behind the ear
V5254	Hearing aid, digital, monaural, completely in the ear canal
V5255	Hearing aid, digital, monaural, in the canal
V5256	Hearing aid, digital, monaural, in the ear
V5257	Hearing aid, digital, monaural, behind the ear

Hearing Aid Binaural

Binaural aids should be billed with one unit.

Procedure Code	*Description*
V5100	Hearing Aid, bilateral, body worn
V5120	Binaural, body
V5130	Binaural, in the Ear
V5140	Binaural, behind the Ear
V5150	Binaural, glasses
V5210	Hearing aid, bicros, in the Ear
V5220	Hearing aid, bicros, behind the Ear

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Procedure Code	Description
V5250	Hearing aid, digitally programmable analog, binaural, completely in the ear canal
V5251	Hearing aid, digitally programmable analog, binaural, in the canal
V5252	Hearing aid, digitally programmable analog, binaural, in the ear
V5253	Hearing aid, digitally programmable analog, binaural, behind the ear
V5258	Hearing aid, digital, binaural, completely in the ear canal
V5259	Hearing aid, digital, binaural, in the canal
V5260	Hearing aid, digital, binaural, in the ear
V5261	Hearing aid, digital, binaural, behind the ear
V5211	Hearing aid, contralateral routing system, binaural, in the ear
V5212	Hearing aid, contralateral routing system, binaural, in the ear, in the ear canal
V5213	Hearing aid, contralateral routing system, binaural, in the ear, behind the ear
V5214	Hearing aid, contralateral routing system, binaural, in the ear canal
V5215	Hearing aid, contralateral routing system, binaural, in the ear canal, behind the ear
V5221	Hearing aid, contralateral routing system, binaural, behind the ear

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

Hearing Aid Accessories

Procedure Code	Description
V5298	Hearing aid, not otherwise classified
V5266	Battery for use in hearing device (1 package for monaural aid and 2 packages for binaural aid every 2 months)
V5264	Ear Mold (1 package for monaural aid and 2 packages for binaural aid every 4 months)
V5014	Factory Repair of hearing aid, out of warranty (1 every 6 months for use with monaural aid and 2 every 4 months with binaural aid)
V5267	Hearing aid supplies/accessories include, but not limited to chin strap, clips, boot, and headband

When billing for hearing services, replacement items and supplies, providers should bill the actual acquisition cost.

10.3 Prior Authorization (PA) and Referral Requirements

Hearing services procedure codes generally do not require a PA. Any service warranted outside of these codes must have a PA. Refer to Chapter 4, Obtaining Prior Authorization, for general guidelines.

When filing claims for recipients enrolled in the ACHN Program, refer to Chapter 40, to determine whether your services require a referral from the Primary Care Physician (PCP). When an EPSDT referral is required for treatment of medically necessary services, the Alabama Medicaid Referral Form (Form 362) must be appropriately completed by the screening physician including the screening date that the problem was identified and the reason for the referral.

10.4 Cost Sharing (Copayment)

Copayment does not apply to hearing services.

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10.5 Completing the Claim Form

NOTE:

An audiologist employed by a physician cannot file a claim for the same services billed by that physician for the same patient, on the same date of service.

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

Hearing services providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claims processing turnaround
- Ability to immediately correct claim errors
- Online adjustments capability
- Enhanced access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When filing a claim on paper, a CMS-1500 claim form is required Medicare-related claims must be filed using the Medical Medicaid/Medicare-related Claim Form.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

10.5.1 Time Limit for Filing Claims

Medicaid requires all claims for hearing services to be filed within one year of the date of service. Refer to Chapter 5 Filing Limits and Approved Exceptions, for more information regarding timely filing limits and exceptions.

10.5.2 Diagnosis Codes

Hearing aid dealers must bill with one of the following ICD-10 diagnosis codes: Z01.10, Z01.110, Z01.118, and Z01.12.

NOTE:

ICD-10 codes should be used for claims submitted with dates of service on/after 10/01/2015.

Audiologists are required to use a valid ICD-10 diagnosis code. The International Classification of Diseases - 10th Revision - Clinical Modification (ICD-10-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, AMA Plaza 330 North Wabash Ave, Suite 39300 Chicago, IL 60611-5885 or 1-800-621-8335.

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10.5.3 Place of Service Codes

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

POS Code	*Description*
11	Office

10.5.4 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to claims with third party denials.

NOTE:

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

Refer to Chapter 5 for more information on required attachments.

10.6 For More Information

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

Resource	Where to Find It
CMS-1500 Claim Filing Instructions	Chapter 5
Medical Medicaid/Medicare-related Claim Filing Instructions	Chapter 5
Medical Necessity/Medically Necessary Care	Chapter 7
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N

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11

11 Chiropractor

Chiropractors are enrolled only for services provided to QMB recipients or to recipients referred as a result of an EPSDT screening.

Policy provisions for chiropractors associated with EPSDT can be found in the *Alabama Medicaid Agency Administrative Code,* Chapter 11.

11.1 Enrollment

Alabama Medicaid's fiscal agent enrolls chiropractors and issues provider contracts to applicants who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code*, and the *Alabama Medicaid Provider Manual*.

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

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

National Provider Identifier, Type, and Specialty

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

NOTE:
The 10-digit NPI is required when filing a claim.

Chiropractors are assigned a provider type of 15. Valid specialties for chiropractors include the following:

- Chiropractor (150)
- QMB/EPSDT (600)

Enrollment Policy for Chiropractors

To participate in the Medicaid program, chiropractors must have a current certification and/or be licensed to practice and operate within the scope of practice established by the state's Board of Chiropractic Examiners.

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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. Refer to Chapter 7, Understanding Your Rights and Responsibilities as a Provider, for general criteria on Medical Necessity/ Medically Necessary Care.

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 Alabama Coordinated Health Network (ACHN) Program, refer to Chapter 40 to determine whether your services require a referral from the Primary Care Physician (PCP).When an EPSDT referral is required for treatment of medically necessary services, the Alabama Medicaid Referral Form (Form 362) must be appropriately completed by the screening physician including the screening date that the problem was identified and the reason for the referral.

Signature Requirement for Referrals: Effective May 16, 2012:
For hard copy referrals, the printed, typed, or stamped name of the primary care physician with an original signature of the physician or designee is required. **Stamped or copied signatures will not be accepted**. For electronic referrals, provider certification is made via standardized electronic signature protocol.

11.4 Cost Sharing (Copayment)

The copayment amount for office visit* including crossovers is:

$3.90 for procedure codes reimbursed $50.01 and greater
$2.60 for procedure codes reimbursed between $25.01 and $50.00
$1.30 for procedure codes reimbursed between $10.01 and $25.00

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

99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

Copayment does not apply to services provided for pregnant women, nursing home residents, recipients less than 18 years of age, emergencies, and family planning. Native American Indians that present an "active user letter" issued

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by Indian Health Services (IHS) will be exempt from the Medicaid required copayment.

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

11.5 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

Chiropractors who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When filing a claim on paper, a CMS-1500 claim form is required. Medicare-related claims must be filed using the Medical Medicaid/Medicare-related Claim Form.

This section describes program-specific claims information. Providers should refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

11.5.1 Time Limit for Filing Claims

Medicaid requires all claims for chiropractors to be filed within one year of the date of service. Refer to Chapter 5 for more information regarding timely filing limits and exceptions.

11.5.2 Diagnosis Codes

The *International Classification of Diseases - 10th Revision - Clinical Modification* (ICD-10-CM) manual lists required diagnosis codes. . These manuals may be obtained by contacting the American Medical Association, AMA Plaza 330 North Wabash Ave, Suite 39300 Chicago, IL 60611-5885 or 1-800-621-8335.

NOTE:

ICD-10 codes should be used for claims submitted with dates of service on/after 10/01/2015.

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NOTE:

ICD-10 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

11.5.3 Procedure Codes and Modifiers

Chiropractors use the Current Procedural Terminology (CPT) coding system. The CPT manual lists most Medicaid required procedure codes. This manual may be obtained by contacting the Order Department, American Medical Association, P. O. Box 930876, Atlanta, GA 31193-0873 or 1-800-621-8335.

11.5.4 Place of Service Codes

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

POS Code	*Description*
11	Office

11.5.5 Required Attachments

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

- Claims with Third Party Denials

NOTE:

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

Refer to Chapter 5 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
Medical Medicaid/Medicare-related Claim Filing Instructions	Chapter 5
Medical Necessity/Medically Necessary Care	Chapter 7
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

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).

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

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

National Provider Identifier, Type, and Specialty

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

NOTE:
The 10-digit NPI is required when filing a claim.

CORF providers are assigned a provider type of 01 (Hospital). The valid specialty for CORF providers is Rehabilitation Hospital (012).

Change of Ownership (CHOW) and Closures

Medicaid will mirror Medicare's Change of Ownership (CHOW) Policy Refer to Chapter 19, Hospital for additional information on Change of Ownership

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. Refer to Chapter 7, Understanding Your Rights and Responsibilities as a Provider, for general criteria on Medical Necessity/ Medically Necessary Care.

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CORF providers are limited to Medicare-related claims billed on the UB-04 claim form.

12.3 Prior Authorization and Referral Requirements

CORF procedures do not require prior authorization or referrals since they are limited to Medicare crossovers only.

12.4 Cost Sharing (Copayment)

Copayment does not apply to services provided by CORF providers.

12.5 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, provider should bill Medicaid claims electronically.

CORF providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When filing a claim on paper, a UB-04 claim form is required. Medicare-related claims must be filed using the Institutional Medicaid/Medicare Related Claim Form.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

12.5.1 Time Limit for Filing Claims

Medicaid requires all claims for CORF to be filed within one year of the date of service. Refer to Section 5.1.4, Filing Limits, for more information regarding timely filing limits and exceptions.

12.5.2 Diagnosis Codes

The *International Classification of Diseases - 10th Revision - Clinical Modification* (ICD-10-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, AMA Plaza, 330 N. Wabash Ave, Chicago, IL 60610-5885, or 1-800-621-8335.

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NOTE:

ICD-9 codes should be used for claims submitted with dates of service prior to or equal to 09/30/2015.

ICD-10 codes should be used for claims submitted with dates of service on/after 10/01/2015.

NOTE:

ICD-9 or ICD-10 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

12.5.3 Revenue Codes

CORF providers use the revenue codes identified by Medicare.

12.5.4 Place of Service Codes

Place of service codes do not apply when filing the UB-04 claim form.

12.5.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to claims with third party denials.

NOTE:

When an attachment is required, a hard copy Institutional Medicaid/Medicare-related claim form must be submitted.

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

12.6 For More Information

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

Resource	Where to Find It
UB-04 Claim Filing Instructions	Section 5.3
Institutional Medicaid/Medicare-related Claim Filing Instructions	Section 5.6.2
Medical Necessity/Medically Necessary Care	Chapter 7
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

13 Dentist

Certain dental health care services are available for eligible children as part of the Early and Periodic Screening, Diagnosis, and Treatment up to age 21 as long as the child remains eligible for Medicaid **with the exception of SOBRA children** who cease to be eligible upon reaching their 19th birthday.

Certain dental services are provided to pregnant Medicaid eligible individuals over 21.

Dental services are any diagnostic, preventive, or corrective procedures administered by or under the direct supervision of a licensed dentist. Such services include treatment of the teeth and the associated structures of the oral cavity, and of disease, injury, or impairment, which may affect the oral or general health of the individual.

As defined in the Rules of The Board of Dental Examiners of Alabama, Rule 270-X3.06, “Direct supervision is defined as supervision by a dentist who authorizes the intraoral procedure to be performed, is physically present in the dental facility, and available during the performance of the procedure, and takes full professional responsibility for the completed procedure”.

Any facility that utilizes unlicensed graduate dentists to treat Medicaid Recipients must meet the requirements set forth in Section 270-X-4.02 of the Dental Practice Act.

NOTE:

For claims processing questions please call Gainwell Provider Assistance Center at 1-800-688-7989.

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

NOTE:

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13.1 Enrollment

Gainwell 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*.

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

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

National Provider Identifier, Type, and Specialty

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

NOTE:

The 10-digit NPI is required when filing a claim.

Dental providers are assigned a provider type of 27 (Dentist). Valid specialties for dental providers include the following:

- General Dentistry (271)
- Oral and Maxillofacial Surgery (272)
- Endodontist (275)
- Pediatric Dentistry (276)
- Orthodontist (277)
- Periodontist (278)

Added: Dental Anesthesiology (279)

- Dental Anesthesiology (279)
- Mobile Provider (299)
- Anesthesiologist (311)

Oral Surgeons are assigned a provider type of 62, depending on the source of the licensure information sent to the Gainwell provider enrollment unit. The valid specialty for Oral Surgeons is Oral and Maxillofacial Surgery (272).

Oral Surgeons billing medical procedures or CPT procedure codes should refer to Chapter 28, Physician and Chapter 5, Filing Claims. Dental procedures (current CDT procedure codes) should always be billed on the ADA dental claim form—Version ADA 2006. **Effective June 1, 2017, use the 2012 ADA Dental Claim Form.**

Added: Dentist or Oral…the fiscal agent.

Dentists or Oral Surgeons may add specialty 279 to bill for general anesthesia in office settings upon submitting documentation verifying completion of an accredited dental anesthesiology residency program to the fiscal agent.

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Enrollment Policy for Dental Providers

To participate in the Alabama Medicaid Program, dental providers must be licensed to practice in the state where care is provided. Each dental provider **must** enroll with a NPI that will follow them to each office location (a Service Location Provider Number will be assigned for each office location to assist in identifying where the service was provided). This also applies for reimbursement for preventive services and must be performed at a fixed physical office location. Each claim filed constitutes a contract with the Alabama Medicaid Agency. Dental providers are required to complete and sign a coding sheet (often referred to as a "super bill") listing all procedure codes/ descriptions performed on each date of service for each Medicaid recipient. For audit purposes, these coding sheets are required to be maintained on file for a period of three (3) years from the date of service.

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

Out of state providers must follow the enrollment procedures of the Alabama Medicaid Agency, please refer to Chapter 2 - Becoming a Medicaid Provider. All program policies apply regardless of where care is provided.

Change of Ownership (CHOW) and Closures

Medicaid will mirror Medicare's Change of Ownership (CHOW) policy.
Refer to Chapter 19, Hospital for additional information on Change of Ownership.

Enrollment of Mobile Dental Clinics

A mobile dental facility or portable dental operation (Mobile Dental Clinic) is any self-contained facility in which dentistry or dental hygiene is practiced which may be moved, towed, or transported from one location to another.

Mobile Dental Clinics shall comply with all Medicaid rules and regulations as set forth in the State Plan, Alabama Medicaid Administrative Code, Code of Federal Regulations and applicable Medicaid billing manuals.

In order to enroll as a Mobile Dental Clinic, an operator shall:

(a) obtain a certificate of registration issued by the Board of Dental Examiners (the Board); and

(b) complete an Alabama Medicaid Provider Enrollment application.

Mobile Dental Clinics shall comply with the following consent requirements:

(a) The operator of a Mobile Dental Clinic shall not perform services on a minor without the signed consent from the parent or guardian. The consent form shall be established by the Board.
(b) The consent form shall inquire whether the prospective patient has received dental care from a licensed dentist within one year and if so, the consent form shall request the name, address, and phone number of the dental home. If the information provided to the operator does not identify a dental home for the prospective patient, the operator shall contact the

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Alabama Medicaid Agency for assistance in identifying a dental home for Medicaid eligible patients. If this information is provided to the operator, the operator shall contact the designated dental home by phone, facsimile, or electronic mail and notify the dental home of the prospective patient's interest in receiving dental care from the operator. If the dental home confirms that an appointment for the prospective patient is scheduled with the dentist, the operator shall encourage the prospective patient or his or her guardian to seek care from the dental home.

(c) The consent form shall document that the patient, or legal guardian, understands the prospective patient has an option to receive dental care from either the Mobile Dental Clinic or his or her designated dental home if applicable.
(d) The consent form shall require the signature of a parent or legal guardian.

Each Mobile Dental Clinic shall maintain a written or electronic record detailing all of the following information for each location where services are performed:

(a) The street address of the service location.
(b) The dates of each session.
(c) The number of patients served.
(d) The types of dental services provided and the quantity of each service provided.
(e) Any other information requested by rule of the Board or Medicaid.

At the conclusion of each patient's visit to the Mobile Dental Clinic, the patient shall be provided with a patient information sheet which shall also be provided to any individual or entity to whom the patient has consented or authorized to receive or access the patient's records. The information sheet shall include at a minimum the following information:

(a) The name of the dentist or dental hygienist, or both, who performed the services.
(b) A description of the treatment rendered, including billing service codes and fees associated with treatment and tooth numbers when appropriate.
(c) If applicable, the name, address, and telephone number of any dentist to whom the patient was referred for follow-up care and the reason for such referral.
(d) The name, address, and telephone number, if applicable, of a parent or guardian of the patient.

Mobile Dental Clinics shall comply with the following requirements for Emergency Follow-up Care:

(a) The operator shall maintain a written procedure for emergency follow-up care for patients treated in a Mobile Dental Clinic, which includes arrangements for treatment and follow-up care by a qualified dentist in a dental facility that is permanently established within a 50-mile radius of where mobile services are provided.

(b) An operator who either is unable to identify a qualified dentist in the area or is unable to arrange for emergency follow-up care for patients otherwise shall be obligated to provide the necessary follow up via the Mobile

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Dental Clinic or the operator may choose to provide the follow-up care at his or her established dental practice location in the state or at any other established dental practice in the state which agrees to accept the patient.

(c) An operator who fails to arrange or provide follow-up care as required herein shall be considered to have abandoned the patient, and will subject the operator and any dentist or dental hygienist, or both, who fail to provide the referenced follow-up treatment to termination as a Medicaid provider.

The provider shall not charge Medicaid for services rendered on a no-charge basis to the general public.

A Mobile Dental Clinic that accepts or treats a patient but does not refer patients for follow-up treatment when such follow-up treatment is clearly necessary, shall be considered to have abandoned the patient and will subject the operator and any dentist or dental hygienist, or both, who fails to provide the referenced follow-up treatment to termination as a Medicaid provider.

Mobile Dental Clinics shall comply with the following requirements for sale or cessation of operation:

(a) In the event a Mobile Dental Clinic is to be sold, the current provider shall inform the Board and Medicaid, at least 10 days prior to the sale being completed and shall disclose the purchaser to the Board and Medicaid, via certified mail within 10 days after the date the sale is finalized.

(b) The provider shall notify the Board and Medicaid, at least 30 days prior to cessation of operation. Such notification shall include the final day of operation, and a copy of the notification shall be sent to all patients and shall include the manner and procedure by which patients may obtain their records or transfer those records to another dentist.

(c) It is the responsibility of the provider to take all necessary action to ensure that the patient records are available to the patient, a duly authorized representative of the patient, or a subsequent treating dentist. For purposes of this subsection, a patient shall mean any individual who has received any treatment or consultation of any kind within two years of the last date of operation of the Mobile Dental Clinic.

NOTE:

If you are already a Medicaid Provider, you do not have to re-enroll with Medicaid to be a Mobile Dental Provider. As a mobile dental provider you will need to submit a request to Gainwell Provider Enrollment, P.O. 241685, Montgomery, AL 36124, to add the mobile provider specialty (299) to your existing provider file along with a copy of your certification received from the Alabama Dental Board. **When filing claims for mobile dental services please indicate your place of service as 15.**

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13.2 1st Look – The Oral Health Risk Assessment and Dental Varnishing Program

Medicaid covers the application of fluoride varnishes for children 6 months through 35 months of age who have a high caries risk based on the risk assessment by **medical providers or their clinical staff (RNs, PAs, Nurse Practitioners, LPNs) that have received the 1st Look Training.** This assessment and varnish program is to be incorporated into the well child visit and be part of the comprehensive care in a medical home. The medical provider and staff must be trained in oral health risk assessment, anticipatory guidance and fluoride varnish application. This training includes oral health risk assessment, education on performing anticipatory guidance/counseling, demonstration of fluoride varnish application and the provision of information on recommendations for a dental home. Upon completion of the oral health risk assessment training program for pediatricians and other child health professionals**, a specialty indicator (274)** will be added to the provider file in order for the provider to receive reimbursement.

NOTE:

The trained provider does not include the nurse practitioner under his/her practice. An enrolled nurse practitioner that has been trained in the 1st Look program can bill for the 1st Look services provided.

Once training is completed, submit an **Electronic Enrollment Update** (**Provider Secure Portal**). Attach a request for adding specialty 274 to the location needed. Provide supporting documentation of the training (Certificate of Completion). The effective date of the specialty is the same as the date of certification.

Dental Home as defined by the American Dental Association – The ongoing relationship between who is the Primary Dental Care Provider and the patient, which includes comprehensive oral health care, beginning no later than age one, pursuant to ADA policy.

A list of Medicaid Dental Providers is available on the Medicaid website under the Provider Directory tab.

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Medical providers will be able to bill in accordance with Medicaid reimbursement policies for the oral assessment (D0145) and the applications of the fluoride varnish (D1206).

Procedure D0145 may be billed **once by the pediatric medical provider and once by the dental provider for children age 6 months through 35 months of age.** Records must document the content of anticipatory guidance counseling given to parents/caregivers, the results of the Caries Assessment Tool (CAT) and that a referral has been made to the ACHN Care Coordinators for all high-risk children. Documentation must also include where referral to a dental home has been made.

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NOTE:

At least two high risk indicators must be present in the high risk category to classify a child as being high risk.

Procedure D1206 will be **limited to three per calendar year with a 90 day limitation between applications**, regardless of the provider and cannot exceed a maximum of six fluoride varnish applications **between 6 months through 35 months of age.** Once a recipient is referred to a dental home, D1206 (application of fluoride varnish) is no longer a covered service when performed by the 1st Look Medical Provider.

13.3 Patient Record

The patient record shall include the following:

1. Patient's full name, address and treatment date;
2. Patient's nearest relative or responsible party;
3. Current health history, including chief complaint, if applicable, and a listing of all current medications;
4. Diagnosis of condition
5. Specific treatment rendered and by whom; (e.g. Tooth #04 DO resin 1.8 cc of Lidocaine by Dr. Smith)
6. After each date of service, the Rendering Provider's **SIGNATURE** must be present after the written documentation of the service in the Patient's Operative Notes. Reimbursement for services **without** the Rendering Provider's SIGNATURE in the Patient's Operative Notes is subject to **recoupment**.
7. Signature electronic or written, or Provider's initials.
8. Name and strength of any medications prescribed, dispensed or administered along with the quantity, date provided and authorized refills;
9. Treatment plan;
10. Applicable radiographs;
11. Informed consent.
12. 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. (5.1.6)

13.4 Informed Consent

Informed consent shall be documented in the record for all patients for whom any treatment, including non-invasive treatment (i.e. cleaning, exams, sealants, SDF), is to be provided. The informed consent is valid for 6 months. The consent form should be procedure specific and include the following:

- Name and date of birth of patient;
- Name and relationship to the patient/legal basis on which the person is consenting on behalf of the patient;
- Description of the procedure in simple terms;
- Disclosure of known adverse risk(s) of the proposed treatment specific to that procedure;
- Professionally-recognized or evidence-based alternative treatment(s) to recommended therapy and risk(s);

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- Place for custodial parent or legal guardian to indicate that all questions have been asked and adequately answered;
- Places for signatures of the custodial parent or legal guardian, dentist, and office staff member as a witness.

Consistent violation of the informed consent requirement can result in further investigation and appropriate action.

13.5 Benefits and Limitations

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

Medicaid reimburses for services that are determined medically necessary and do not duplicate another provider's service. In addition, the services must meet the following criteria:

- The services must be individualized, specific, consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of recipient's needs.
- The services cannot be experimental or investigational.
- The services must reflect the level of services that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide; and
- The services must be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

Covered procedures are located in section 13.8.2

13.5.1 Adult Pregnant Recipients

Effective October 1, 2022, Alabama Medicaid covers dental services for pregnant adult recipients (over 21). Coverage is effective during pregnancy and through the end of the month of 60 days post partum.

Dental Reimbursement Requirements

Verify eligibility (Keep verification in the patient's record)

Get written attestation (self report) from the recipient that she is pregnant. Attestation must include recipient's signature, estimated date of delivery and date signed (keep in the dental records)

File D9999 on the claim (this pregnancy indicator must be filed on the claim for it to be paid.

13.5.2 Orthodontic Services

Medicaid provides medically necessary orthodontic services for eligible and qualified recipients. Orthodontic services must be requested through a multidisciplinary clinic administered by Alabama Children's Rehabilitation Service at 1(800) 441-7607or another qualified clinic enrolled as a contract vendor in the Medicaid Dental Program. All medically necessary orthodontic treatment must be prior authorized by Medicaid before services are provided.

Requests for orthodontic services must include the recommendations of the multidisciplinary team, photos and x-rays.

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Criteria for coverage include the following diagnoses when medical necessity exists:

- Cleft palate or cleft lip deformities
- Cleft lip with alveolar process involvement
- Velopharyngeal incompetence
- Short palate
- Submucous cleft
- Alveolar notch
- Craniofacial anomalies included but not limited to
- Hemifacial microsomia
- Craniosynostosis syndromes
- Cleidocranial dysplasia
- Arthrogryposis
- Marfan's syndrome
- Apert's syndrome
- Crouzon’s Syndrome
- Other syndromes by review
- Trauma, diseases, or dysplasias resulting in significant facial growth impact or jaw deformity.

NOTE:

Extractions for orthodontic purposes are not covered unless there is a Medicaid approved orthodontia case.

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

- Dento-facial Anomaly, NOS (not otherwise specified)
- Orofacial Anomaly, NOS
- Severe Malocclusion

NOTE:

Procedures billable only by Alabama Children’s Rehabilitation Service providers:

D8080 – Comprehensive orthodontic treatment of the adolescent dentition

D8680 – Orthodontic retention (removal of appliances, construction and placement of retainer(s))

D9310 – Consultation – diagnostic service provided by dentist or physician other than requesting dentist or physician.

13.5.3 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:

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- Procedures which are not necessary or do not meet accepted standards of dental practice based on scientific literature. This will be determined thru review of submitted radiographs and written documentation which must support the medical necessity of the service rendered.
- Surgical periodontal treatment (Exceptions require prior authorization: Pharmaceutically induced hyperplasia and idiopathic juvenile periodontosis).
- Orthodontic treatment (Exception: medically necessary orthodontic services after evaluation by CRS and referral to the Alabama Medicaid Agency for prior authorization. See section 13.5.1 for additional information).
- Prosthetic treatment, such as fixed or removable bridgework (D6240 and D6750), or full or partial dentures (Exceptions require prior authorization: prosthesis for closure of a space created by the removal of a lesion or due to congenital defects (permanent tooth congenitally missing).
- Panoramic films on recipients under age 5.
- Dental transplants
- Dental implants
- Prosthetic implants
- Esthetic veneers
- Silicate restorations
- Pulp caps on primary teeth
- Pulpotomies on permanent teeth
- Space maintainers for premature loss of primary incisors or as “pedo bridges”
- Space maintainers placed greater than 180 days after the premature loss of a primary tooth
- Space maintainers placed where the extracted tooth was a restorable tooth
- Space maintainers for teeth A, J, K, T, M and R for recipients greater than 14 years of age
- Space maintainers for teeth B, I, L and S age eight years and older
- Bilateral space maintainer for teeth C and H
- Repair of a damaged space maintainer or replacement of a lost space maintainer
- D2940 for teeth A-T for recipients greater than 6 years of age and older
- D2951 for teeth A-T
- D3220 and D3230 for teeth N, O, P and Q
- D4355 for recipients under age 6
- D1120 for recipients less than 3 years of age
- Non-diagnostic radiographs
- Extraction of exfoliating primary teeth without a valid indication (e.g. pain, eruption interference, abscess, etc.) documented in the record
- Acrylic, plastic restorations (class III or V)

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- Acrylic, plastic restorations (class IV)
- Plastic crowns (acrylic)
- Permanent crowns, core buildups, and post & cores on recipients under the age of 15
- Adult Dental Care
- Temporomandibular joint disorder

Palliative (emergency) treatment (D9110) is not covered when billed with another therapeutic (definitive) procedure but can be billed with diagnostic procedures.

Refer to other non-covered or non-billable services in the policy provisions for dental providers that can be found in the *Alabama Medicaid Agency Administrative Code,* Chapter 15.

13.6 Prior Authorization (PA) and Referral Requirements

Prior authorization from Medicaid is required for the following services:

- Periodontal treatment (scaling and root planing, periodontal maintenance procedures)
- Excision of hyperplastic tissue
- Space maintainers (after the first two)
- Apicoectomy/periradicular surgery
- Removal of completely bony impactions
- Home visits or treatment of any recipient under age 21 in a licensed medical institution (nursing facility)
- Diagnostic models (when requested by Medicaid)
- Therapeutic drug injection (by report)

NOTE:
Prior authorization does not guarantee eligibility. Providers are responsible for verifying eligibility prior to rendering services.

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

13.6.1 Obtaining Prior Authorization (PA) for Dental Services

Emergency Prior Authorizations

In an emergency situation where the delay for written request of prior authorization would endanger the health of the recipient, initiate the prior authorization by contacting Gainwell/Dental PA Unit at (334) 523-4144. Please be sure to include all the information listed below. If the emergency situation occurs after hours, on weekends, or on a holiday, a voice message will be accepted. The voice mail message must include the following information:

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- Recipient's name
- Recipient's Medicaid number (13 digits)
- NPI of dentist
- Phone number of dentist, including area code

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- Nature of emergency
- Contact person, if other than dentist for follow-up

A paper or electronic PA request must be received by Gainwell within ten business days of the telephone call and or voice message request. If the request is not received within ten business days of the telephone call, the PA will be denied. The request must meet established guidelines and criteria.

Paper PA Requests

Providers must use the Prior Review and Authorization Dental Request Form (form 343, revised 5/28/13) to request prior authorization for procedures requiring a prior authorization (e.g., D7241 removal of impacted tooth, etc.) as noted in section 13.6. All sections of this form must be completed. If the form is not completed in its entirety or if the PA request is submitted on any other form, the request will be denied. The form 343 should be forwarded to:

Gainwell Dental PA Unit
P.O. Box 244032
Montgomery, AL 36124-4032

or

301 Technacenter Drive
Montgomery, AL 36117

Paper PA requests will be held for up to 10 business days to allow sufficient time for supporting documentation to be received and processed. If supporting documents are not received in this time period, the PA will be denied, and a new PA request must be submitted. Beginning May 1, 2017, the required documentation must be submitted via upload or fax transmission. See Submitting Dental PA Supporting Documentation section for details.

Electronic PA Requests

Providers may use Medicaid's Web Portal or PES software to submit an electronic PA for those procedures requiring a prior authorization (e.g., D7241 removal of impacted tooth, etc.) When submitting an electronic request, select "Dental" if the service is being performed in the dental office. Select "Surgical" if the service is being performed in hospital setting**.**

Electronic PA requests will be held for up to 10 business days to allow sufficient time for documentation to be received and processed. If supporting documents are not received in this time period, the PA will be denied and a new PA request must be submitted.

Beginning May 1, 2017, the required documentation must be submitted via upload or fax transmission. See Submitting Dental PA Supporting Documentation section for details.

NOTE:

Electronic PA Requests via PES:

Please include a copy of the Prior Authorization response, which is received after your submission, with your PA supporting documentation. For details, refer to section 4.3 PA Requests Requiring Supporting Documentation on submitting PA supporting documentation using the Web Portal.

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Reconsideration of Denied PA Requests

Requests for reconsideration of a denied PA must include additional information that justifies the need for the requested service(s). The Agency's fiscal agent, Gainwell, must receive this request for reconsideration within 30 days from the date of the denial letter, or the decision will be final and no further review will be available.

Reconsideration requests may be electronically uploaded using the same process as for the initial upload of the supporting documentation. See Submitting Dental PA Supporting Documentation section for details. When submitting supporting documentation, check the reconsideration box at the top of the PA request to indicate it is a reconsideration request.

Submitting Dental PA Supporting Documentation

Effective May 1, 2017, supporting documents for Dental prior authorizations will be accepted only by upload or fax via the Forms menu of the Alabama Medicaid Interactive Web Portal. Paper/original photos, film X-rays or radiographs will still be accepted by mail after May 1, 2017.

The Web Portal allows submission of supporting documentation via two methods: (1) Documents may be uploaded directly via pdf format to the Web Portal or (2) the Web Portal will generate a fax barcode cover sheet that can be printed and used with all documents to be faxed. The barcode cover sheet also allows additional documentation to be submitted and combined with original documents.

Refer to Chapter 4, section 4.3.2, Obtaining Prior Authorization for instructions on submitting Dental PA supporting documentation via the Web Portal.

PA requests will be held for up to 10 business days to allow sufficient time for documentation to be received and processed. If supporting documents are not received in this time period, the PA will be denied and a new PA request must be submitted.

Please note providers will be able submit paper/original photos, film X-rays or radiographs via mail after May 1, 2017. The radiographs must have the corresponding PA number identified in the upper right hand corner of each page so they can be matched to the paper or electronic PA request.

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NOTE:

Additional Instructions for Completing PA Request:

- For treatment in the dental office:

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

- For treatment in outpatient/inpatient hospital or nursing facility:

  When completing the Alabama Prior Review and Authorization Dental Request (Paper or Electronic), list procedures planned if the dental procedure code requires prior authorization. However, the dental record and supporting PA documents submitted should include all treatment planned.

Providers cannot charge or collect money from the recipient to schedule a service or guarantee patient compliance.

Refer to Chapter 4, Section 4.4, Obtaining Prior Authorization, for instructions on obtaining prior authorization and completion of the form. PA requests may be submitted via paper, web portal or PES**.**

Prior authorization requests take approximately three to four weeks for processing. Providers should call the Provider Assistance Center (PAC) at 1(800) 688-7989 to verify request is in the system if approval/denial is not received within this time frame.

Added: general

Added: Information is available…title, "Dental Forms."

NOTE:

For general information on Administrative Reviews, see Chapter 7, Section 7.2.1.

Information is available on the Agency website which provides detailed directions for submitting a Dental Administrative Review form electronically via the Provider Interactive Web Portal. Visit www.medicaid.alabama.gov. Select the Programs tab, Dental Program, and look under the title, "Dental Forms."

13.6.2 Criteria for Prior Authorization

This section discusses specific criteria for prior authorization for certain periodontal and preventive anesthetic. There are additional dental procedures that require prior authorization as indicated in Section 13.8.2, Procedure Codes.

Documentation Necessary for Dental Services Provided in a Hospital Setting Requiring Dental Prior Authorization (For recipients age 5 or older)

Prior authorization for patients **5** years through 20 years of age, at least one of the following criteria justifying use of general anesthesia in the hospital must be met:

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1. Child or adolescent who requires dental treatment has a physical or mentally compromising condition
2. Patient has extensive orofacial and dental trauma
3. Procedure is of sufficient complexity or scope to necessitate hospitalization; the mere extent of caries or large quantity of teeth to be treated, or preference to provide all treatment in one appointment, or need for premedication, are not, by themselves, qualifying reasons for hospitalization.
4. Child who requires dental treatment is extremely uncooperative due to acute situational anxiety, attention deficit disorder, or emotional disorder (requires an additional report described in a. – k. below)

Approval is typically given for a specified time frame not to exceed six months. Treatment must be dentally necessary and supported by a treatment plan and appropriate radiographs. Requests for treatment in a hospital setting based on lack of cooperation, anxiety, attention deficit disorder, or emotional disorder are not typically approved when the dental history shows treatment was rendered in the office in the past.

Documentation from the medical record justifying one or more of the above four criteria is required to be submitted with the Prior Authorization request along with a completed Informed Consent. **On children under age 5, documentation in the record will be required to support the necessity of the treatment performed in a hospital setting.**

If Criteria number 4 above (without a physical or mental disability) is cited as the justification for treatment in a hospital setting, it additionally requires a report of at least one active failed attempt to treat in the office. This report must include (if applicable):

a. recipient's behavior preoperatively
b. type(s) of behavior management techniques used that are approved by the American Academy of Pediatric Dentistry
c. recipient's behavior during the procedure
d. the use, amount, and type of local anesthetic agent
e. use and dosage of premedication, if attempted
f. use and dosage (%, flow rate and duration) of nitrous oxide analgesia used
g. procedure(s) attempted
h. reason for failed attempt
i. start and end times of the procedure(s) attempted
j. name(s) of dental assistant(s) present in the treatment room
k. presence or absence of parents or guardians in the treatment room

If requirements d, e, or f above were attempted but not successfully accomplished, the report must state the reason(s) for not carrying out or accomplishing these requirements.

If above criteria is met the provider should submit a Prior Authorization request (paper or electronic) listing procedures planned if the dental procedure code

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requires prior authorization. However, the dental record and supporting PA documents submitted should include all treatment planned. If the Prior Authorization is approved, the approval letter will reflect the requested procedure codes showing as pending. The letter will also contain a statement to the effect: "Dental procedures approval **CONTINGENT UPON**: preoperative radiographs *(type will be specified)* being taken at the hospital and submitted with list of treatment procedures rendered directly to: Gainwell Dental PA Unit for review of treatment meeting criteria."

After treatment is completed, a PA update consisting of radiographs and an ADA claim form documenting actual services rendered should be submitted by upload or fax via the Forms menu of the Alabama Medicaid Interactive Web Portal. See Submitting Dental PA Supporting Documentation section in 13.6.1 for details. The submission of a claim form after treatment is completed in a hospital setting is not considered a claim submitted for payment. Refer to Chapter 5 – Filing Claims for information.

Once the prior authorization is reviewed and updated, a letter will be sent to the provider indicating services approved. Upon receipt of the letter, the provider may file their claim for services approved by Medicaid.

Outpatient/ASC Admission (G0330, limited to 4 times per recipient per calendar year)

Effective January 1, 2023, prior authorization is not required for the hospital to bill D9420.

Adult Anesthesia and Facility Fees (G0330, limited to 4 times per recipient per calendar year)

- Coverage may be available for facility and anesthesia charges t 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 that should be documented in the dental record:
    - 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 in the recipient's medical/dental record, which confirms the medical compromise indicated.

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

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13.6.3 Referral Requirements

EPSDT Referral

Dental screenings must be performed on children from birth through age two by observation (subjective) and history. Refer to Appendix A for EPSDT services.

Medicaid supports the recommendations of The American Academy of Pediatric Dentistry which recommend children be enrolled and under the care of a dentist by age one.

Case Management Care Coordination

Alabama's ACHN program requires that Medicaid recipients understand the importance of dental care and how to use the dental health care system. Now, professional case managers in the patient's county of residence can complement the dental services of your practice by working with patients you identify as needing additional assistance.

Referrals should be limited to "special cases" only. These include but are not limited to children with special needs who require follow-up care, children needing assistance with referral for specialty care, and missed appointments for children lost to follow-up during treatments such as root canals.

If you have a child that meets the "special cases" criteria, then refer this patient to the targeted case manager in the patient's county of residence for further screening, support, counseling, monitoring and education. For a list of managers in your area visit the Alabama Medicaid Agency's website at www.medicaid.alabama.gov.

13.7 Cost Sharing (Copayment)

Dental Providers cannot charge Medicaid Recipients, since copayment does not apply to services provided by dental providers.

13.8 Completing the Claim Form

Effective June 1, 2017, all Medicaid dental providers must use the 2012 version of the American Dental Association Dental claim form. The 2006 ADA claim form will be used until May 31, 2017. If you experience problems with Gainwell processing your forms, contact Gainwell for resolution, 1-800-688-7989. Refer to Chapter 5, Filing Claims, Section 5.5, Completing the ADA Dental Form, for complete instructions on filling out the ADA Dental Form.

Medicaid will only reimburse for services that have been completed. Claim form must reflect services that have been completed.

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:

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- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B Electronic Media Claims Guidelines, for more information about electronic filing.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

13.8.1 Time Limit for Filing Claims

Medicaid requires all claims for Dental providers **to be filed within one year of the date of service**. Refer to Chapter 5, Filing Claims, Filing Limits, Section 5.1.5, Filing Limits and Approved Exceptions, for more information regarding timely filing limits and exceptions.

13.8.2 Procedure Codes

Use the code numbers and procedure descriptions as they appear in this section when filling out the ADA dental form. The listing of a procedure in this section does not imply unlimited coverage. **Certain procedures require prior authorization as noted in the PA Required column.**

Effective April 1, 2023, the column in the chart below indicating "Prior Authorization Required" includes if a PA is required in the office setting (place of service 11) and hospital setting (places of service 19, 21, or 22). Certain dental procedure codes no longer require a PA when performed in a hospital setting (places of service 19, 21, or 22) effective April 1, 2023.

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Diagnostic Clinical Oral Examinations

Procedure Code	*Description of Procedure*	*Prior Authorization Required*
D0120	Periodic oral examination is an evaluation a patient of record to determine any changes in the patient's dental and medical health status since a previous comprehensive or periodic evaluation. This may require interpretation of information acquired through additional procedures. Report additional diagnostic procedures separately. This examination is limited to once every six months (per calendar month) for eligible Medicaid recipients. A full six month period between oral exams is not required. For example, if a recipient received an oral exam on January 15, 2002, he or she is eligible for another exam any time in July 2002 (the sixth month). Cannot be billed within 6 months of D0150 by same provider for the same recipient. Non-emergency oral examinations (D0120 and D0150) are limited to 2 (two) per calendar year whether it is a comprehensive oral examination and one periodic oral examination or 2 (two) periodic oral examinations in a 12 month period.	No
D0140	Limited oral evaluation – problem focused (emergency treatment) A limited oral examination is an evaluation or re-evaluation limited to specific health problems. This may require interpretation of information acquired through additional procedures. Report additional diagnostic procedures separately. Definitive procedures may be required on the same day. Typically, recipients receiving this type of evaluation have been referred for a specific problem or are presented with dental emergencies, such as acute infection. Providers using this procedure code must report the tooth number or area (please refer to page 45 for specific instructions) of the oral cavity. Symptom(s), diagnosis, and emergency treatment must be recorded in the dental record where the specific problem is suspected. This procedure cannot be billed in conjunction with periodic or comprehensive oral examinations. Limited to three per recipient per provider/provider group per calendar year.	No

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Procedure Code	***Description of Procedure***	***Prior Authorization Required***
D0145	Oral Evaluation for a Patient Under Three Years of Age and Counseling with Primary Caregiver : This code is intended to be for the first visit to a dental and/or *medical office for a patient under three years of age, for evaluation of caries susceptibility, development of an appropriate preventive oral health regimen and communication with and counseling with the child's parent or guardian. This code will only be allowed once per recipient lifetime (only exception is the 1st Look Program). Cannot be billed on the same date of service as procedure codes D0120 (periodic exam); D0140 (limited oral evaluation) or D0150 (comprehensive oral evaluation). Under the 1st Look Program: D0145 will be billable once by a pediatric medical provider and once by a dental provider for children ages 6 months through 35 months.	No
D0150	A comprehensive oral examination used by a general dentist or specialist when evaluating a recipient comprehensively. It is a thorough evaluation and recording of the extraoral and intraoral hard and soft tissues. This includes an evaluation for oral cancer where indicated, the evaluation and recording of the patient's dental and medical history and a general health assessment. It includes the evaluation and recording of dental caries, missing or unerupted teeth, restorations, existing prostheses, occlusal relationships, periodontal conditions (including periodontal screening and/or charting), hard and soft tissue anomalies, etc. Documentation of the above findings for hard and soft tissues is required even if each finding is normal. This procedure is limited to once per recipient's lifetime per provider or provider group. Cannot be billed within 6 months of D0120 by same provider for the same recipient. Non-emergency oral examinations (D0120 and D0150) are limited to 2 (two) per calendar year whether it is a comprehensive oral examination and one periodic oral examination or 2 (two) periodic oral examinations in a 12 month period.	No

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Radiographs

Radiological procedures are limited to those required to make a diagnosis. The radiographs should show all areas where treatment is anticipated.

A full series consisting of at least 14 periapical and bitewing films OR a panoramic film are permitted every three years if professional judgment dictates. Effective July 1, 2003, panoramic films are limited to age 5 and above. A full series (D0210) uses the panoramic film (D0330) *once every three years* benefit and vice versa.

If **medically necessary**, posterior bitewing and single anterior films may be taken every six months as part of an examination and, subject to the annual limits. **Documentation must support medical necessity**. All periapical films are limited to a maximum of **five** per year per recipient. Exceptions: full mouth series, panoramic film, or a periapical necessary to treat an emergency (submitted by report).

In order to be reimbursed, **all films must be of diagnostic quality suitable for interpretation, mounted in proper x-ray mounts marked Right and Left, and identified by type, date taken, recipient's name, and name of dentist.**

Radiographs of non-diagnostic quality are not chargeable to Medicaid or the recipient.

When billing Intraoral - Periapical, first film (D0220), and Periapical, each additional film (D0230) a tooth number/letter is required in tooth number column on electronic or paper claim.

Any combination of periapical films with or without bitewings taken on the same date of service which exceed the maximum allowed, must be billed as a Complete Intraoral Series (D0210). D0330 uses the benefit of D0210.

Periapical and occlusal films **must have a valid indication** documented in the record (e.g. aid in diagnosing an emergency, endodontic obturation evaluation, etc.) **Routine use of periapical radiographs(s)** at periodic/comprehensive evaluations or treatment appointments without valid documented indications **are not allowable**.

Radiology Guidelines (guidelines do not override benefit limits)

A. Radiographic Examination of the New Patient

Child-Primary Dentition: Posterior bitewing radiographs for a new patient, with a primary dentition and closed proximal contacts.

Child-Transitional Dentition: Individualized periapical/occlusal examination with posterior bitewings OR a panoramic X-ray and posterior bitewings, for a new patient with a transitional dentition.

Adolescent – Permanent Dentition Prior to the eruption of the third molars.

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B. Radiographic Examination of the Recall Patient

1. Patients with clinical caries or other high-risk factors for caries

   a. Child – Primary and Transitional Dentition: Posterior bitewings performed at a 12 month interval for those children with clinical caries or who are at increased risk for the development of caries in either the primary or transitional dentition.

   b. Adolescent: Posterior bitewings performed at a 12 month interval for adolescents with clinical caries or who are at increased risk for the development of caries.

2. Patients with no clinical caries and no other high risk factors for caries

   a. Child-Primary Dentition: Posterior bitewings performed at an interval of 12-24 months for children with a primary dentition with closed posterior contacts who show no clinical caries and are not at increased risk for the development of caries.

   b. Adolescent: Posterior bitewings performed at intervals of 12-24 months for patients with a transitional dentition who show no clinical caries and are not at an increased risk for the development of caries.

3. Patients with periodontal disease, or a history of periodontal treatment for Child – Primary and Transitional Dentition and Adolescent: Individualized radiographic survey consisted of selected periapicals and/or bitewing radiographs of areas with clinical evidence or a history of periodontal disease, (except nonspecific gingivitis).

4. Growth and Development Assessment

   Child- Primary Dentition: Prior to the eruption of the first permanent tooth, no radiographs should be performed to assess growth and development at recall visits in the absence of clinical signs or symptoms.

   Child – Transitional Dentition: Individualized periapical/occlusal series OR a panoramic x-ray to assess growth and development at the first recall visit for a child after the eruption of the first permanent tooth.

   Adolescent: Age 16-19 year of age recall patient, a single set of periapicals of the wisdom teeth or a panoramic radiograph.

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Requests to Override the Panoramic Film Limitation

An override of the 3-year limitation on panoramic films will be considered **only** under the following exceptional circumstances:

a. The provider finds clinical or radiographic evidence of **new** oral disease or a **new** problem that cannot be evaluated adequately using any other type of radiograph, or
b. The recipient's previous provider is unable or unwilling to provide a copy of the previous panoramic film that is of diagnostic quality. (Such cases may result in recoupment of Medicaid's payment for the previous film.)

To request a panoramic override, the provider must submit the following:

a. A properly completed 2006 ADA claim form before May 31, 2017. **(effective June 1, 2017, use the 2012 ADA claim form)**,
b. Copies of the current and previous panoramic films as well as any other radiographs that support the override request, and
c. A cover letter that clearly describes the circumstances of the case.

These requests should be mailed to:

Alabama Medicaid Agency
Dental Program
P.O. Box 5624
Montgomery, AL 36103-5624

Procedure Code	***Description of Procedure***	***Prior Authorization Required***
D0210	Intraoral – Complete series, including bitewings, consists of 14 periapicals and bitewings. Limit once every 3 years. A complete series uses the benefit of a panoramic film. Any combination of D0220, D0230, D0240, D0272, or D0274 taken on the same date of service, which exceeds the maximum allowed fee for D0210 must be billed as D0210	No
D0220	Intraoral – Periapical, first film. Not allowed on the same date of service as D0210. All periapical films are limited to a maximum of five per year per recipient. Exceptions: full mouth series, panoramic film, or a periapical necessary to treat an emergency (submitted by report).	No

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Procedure Code	***Description of Procedure***	***Prior Authorization Required***
D0230	Intraoral – Periapical, each additional film This film is taken **after** the initial film (D0220) Not allowed on the same date of service as D0210 **This film is limited to one per date of service when used in conjunction with D0272 or D0274.**	No
D0240	Intraoral – Occlusal film Requires tooth number. Should not be reimbursed when a periapical film is the appropriate service (D0220 or D0230**). If billed where periapical is more appropriate, reimbursement will be subject to recoupment** **This code is not to be billed when periapicals are billed (D0220 and D0230) for the same area of the mouth as the occlusal film.** **This procedure is limited to two per calendar year, one for the maxillary (teeth C-H) and one for mandibular (teeth N-R) areas only. This code is not to be utilized for single teeth.**	No
D0250	Extraoral – first film	No
D0272	Bitewings – two films Limit 1 every calendar year Not allowed on same the date of service as D0274	No
D0274	Bitewings - four films Limit 1 every calendar year Effective July 1, 2003, procedure restricted to age 13 or older. Not allowed on same the date of service as D0272	No
D0330	Panoramic film Cannot be billed in addition to D0210. A panoramic film uses the benefit of a complete series (D0210) Limited to once per recipient every three years (calendar year), Effective July 1, 2003 procedure restricted to age 5 or older)	No

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Tests and Laboratory Examinations

Procedure Code	*Description of Procedure*	*Prior Authorization Required*
D0470	Diagnostic casts, per model. Models must be trimmed and able to be articulated and must include bases. *Diagnostic casts are authorized only when required by Medicaid.*	Yes

Preventive Services

Dental prophylaxis includes removal of plaque, calculus and stains from the tooth structure in in the primary, transitional and permanent dentition. When billing for prophylaxis and fluoride treatment provided on the same date of service for a recipient, use D1110 and D1208 for recipients over the age of 12 and D1120 and D1208 for children up to and including 12 years of age.

Topical Fluoride Treatment (Office Procedure) D1206 & D1208

Prescription strength fluoride product designed solely for use in the dental/medical office, delivered to the dentition under the direct supervision of a dental professional or an approved medical professional under the 1st Look Program. Fluoride must be applied separately from prophylaxis paste.

Procedure Code	*Description of Procedure*	*Prior Authorization Required*
D1110	Prophylaxis - **Recipient (13 years of age and older)** Limited once every 6 months. (A full six-month period between oral exams is not required. Example: if a recipient received an oral exam on January 15 2002, the recipient is eligible for another exam any time in July 2002 (the sixth month)). Not allowed on the same date of service as: D4341, D4355, or D4910	No
D1120	Prophylaxis - **Recipient (covered for age 3 up to and including 12 years of age)** Limited once every 6 months (A full six-month period between oral exams is not required. Example: if a recipient received an oral exam on January 15 2002, the recipient is eligible for another exam any time in July 2002 (the sixth month)). Not allowed on the same date of service as D4341, D4355, or D4910	No
D1208	Topical application of fluoride (excluding prophylaxis) **Fluoride must be applied separately from prophylaxis paste. Application does not include fluoride rinses or "swish".** Limited once every 6 months (A full six-month period between oral exams is not required. Example: if a recipient received an oral exam on January 15 2002, the recipient is eligible for another exam any time in July 2002 (the sixth month). Not allowed on the same date of service as: D1206	No

Deleted: ~~Recipient (up to…years of age)~~

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Procedure Code	***Description of Procedure***	***Prior Authorization Required***
D1206	Topical Fluoride Varnish, Therapeutic Evaluation for High Risk Caries In order to bill this code the patient must have documented evidence of moderate to high risk caries. This procedure can only be billed once annually beginning age 3. Not allowed on the same date of service as D1208 (topical application of fluoride – child) **NOTE:** For the 1st Look Program: D1206 will be limited to 3 per calendar year, regardless of the provider (medical or dental) not to exceed 6 fluoride varnish applications for children ages 6 months through 35 months.	No
D1351	Sealant, per tooth **Only covered for teeth: 02,03,14,15,18,19,30,31, on children aged 5 through 14 years)** For procedure D1351, teeth to be sealed must be free of caries and restorations. Surface sealed must be noted on the dental claim form. Reimbursement for restorations placed for previously sealed surface by the same provider within a 12 month period will be reduced by the amount of the reimbursement for the sealant. Limit one per tooth per lifetime	No
D1354	Interim caries arresting medicament application – per tooth Limited to 5 per six calendar months. (If it is applied in January it can be applied again any time in July) Limited to 4 applications per tooth per lifetime. Informed consent including pictures of SDF staining. No other treatment allowed on same tooth on the same day of service. Tooth number must be noted on the dental claim form.	No

NOTE:

Multiple visits needed to accomplish an exam, prophy, fluoride and sealants must have documented medical necessity in order for Medicaid payment to be allowable. Payment will be subject to recoupment if documentation does not support the medical necessity for multiple visits to accomplish an exam, prophy, fluoride and sealants.

It is considered fraudulent practice for a provider to intentionally schedule multiple appointments for no medical reason in order to maximize their reimbursement.

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Space Maintainers

Effective July 1, 2003, space maintainers are covered on the following missing teeth ONLY:

1. Premature loss of second primary molar (A,J,K,T)
2. Premature loss of first primary molar (B,I,L,S) except in mixed dentition with normal class I occlusion
3. Premature loss of primary canines (C,H,M,R)

Space maintainers are NON-COVERED in the following instances:

- Repair of a damaged space maintainer or the replacement of a lost space maintainer
- For premature loss of primary incisor teeth or as "pedo bridges"
- Space maintainers placed greater than 180 days after the premature loss of a primary tooth
- More than once per recipient's lifetime for a given space(tooth) to be maintained
- Space maintainers for the loss of permanent teeth
- Space maintainers placed where the extracted tooth was a restorable tooth
- Space maintainer for teeth A, J, K, T, M, R for recipients greater than 14 years of age
- Space maintainers for teeth B, I, L, S after age 8
- Bilateral space maintainer for teeth C and H
- Repair of a damaged space maintainer or replacement of a lost space maintainer

NOTE:

Contraindications to Space Maintainers According to the American Academy of Pediatric Dentistry:

A space maintainer is usually not necessary if there is a sufficient amount of space present to allow for eruption of permanent tooth/teeth.

A space maintainer may not be recommended if severe crowding exists, such that space maintenance is of minimal effect and subsequent orthodontic intervention is indicated.

A space maintainer may not be necessary if the succedaneous tooth will be erupting soon.

Space maintainers, when indicated, should be placed as soon as possible after early primary tooth loss, but no later than 180 days after extraction or loss. On the 181st day, the space maintainer procedure will deny. The claim or prior authorization form must indicate the primary tooth letter that has been prematurely lost/extracted. If more than one deciduous tooth is lost, show the letter of the most recent tooth lost, which will be replaced by the space maintainer. The first two space maintainer procedure codes billed regardless of tooth (i.e. two per mouth) do not require prior authorization, but must meet coverage requirements. Prior authorization with justification is required for the billing of each additional space maintainer procedure code after the first two.

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Procedure Code	*Description of Procedure*	*Prior Authorization Required*
D1510	Space maintainer- fixed, unilateral	Yes (See above)
D1516	Space maintainer- fixed, bilateral - Maxillary	Yes (See above)
D1517	Space maintainer- fixed, bilateral - Mandibular	Yes (See above)
D1520	Space maintainer – removable, unilateral	Yes (See above)
D1526	Space maintainer- removable, bilateral - Maxillary	Yes (See above)
D1527	Space maintainer- removable, bilateral - Mandibular	Yes (See above)
D1551	Re-cement space maintainer Maxillary (re-cementing is limited to two times for a given space maintainer (tooth)	Yes (See above)
D1552	Re-cement bilateral space maintainer Mandibular, (re-cementing is limited to two times for a given space maintainer (tooth)	Yes (See above)
D1553	Re-cement unilateral space maintainer-per quadrant, (re-cementing is limited to two times for a given space maintainer (tooth)	Yes (See Above)

Restorative Services

Effective December 1, 2017, no reimbursement will be allowed for a restoration that involves a surface previously restored on the same tooth within the preceding 12 months for the following procedure codes: D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D7140, D2930, D2931, D2932.

Effective December 1, 2017, no reimbursement will be allowed for any restoration on the same tooth if treated within the previous 6 months for the following procedure codes: D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D7140, , D2930, D2931, D2932, D2940.

Fee for restorative service includes: all adhesives including amalgam or resin bonding agents, lining or base, restoration, and local anesthesia or analgesia, if necessary. **Amalgam or resin restorations are not covered on a tooth receiving any of the following procedures:** stainless steel crowns (D2930, D2931), resin crowns (D2932), core buildups (D2950), post & cores (D2952, D2953, D2954, D2957), or crowns (D2740, D2750, D2751, D2752, or D2792).

Amalgam or resin codes (D2140 – D2394) **may not be billed** in substitution for a core buildup (D2950). Primary tooth restorations are not allowed when normal exfoliation is imminent. Effective July 1, 2005 restorations (D2140 – D2394) **on primary teeth are not covered unless there is greater than one-third of the original root length remaining.**

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Amalgam Restorations (Including Polishing)

Procedure Code	*Description of Procedure*	*Prior Authorization Required*
D2140	Amalgam – one surface, primary or permanent	No
D2150	Amalgam – two surfaces, primary or permanent	No
D2160	Amalgam – three surfaces, primary or permanent	No
D2161	Amalgam – four or more surfaces, primary or permanent	No

Composite Restorations

Resins are not allowed for preventive procedures or cosmetic purposes (e.g. diastema closure, discolored teeth, correction of developmental anomaly, etc.). **Resins are used to restore a carious lesion into the dentin or a deeply eroded area into the dentin**. Reimbursement for enamel only resins may be subject to recoupment when used as a non-preventative measure. Resins must be visible on radiographs with evidence of tooth preparation.

Procedure Code	*Description of Procedure*	*Prior Authorization Required*
D2330	Resin – one surface, anterior	No
D2331	Resin – two surfaces, anterior	No
D2332	Resin – three surfaces, anterior	No
D2335	Resin – four or more surfaces or involving incisal (anterior) angle	No
D2391	Resin - one surface, posterior	No
D2392	Resin - two surfaces, posterior	No
D2393	Resin - three surfaces, posterior	No
D2394	Resin - four or more surfaces, posterior	No

NOTE:

For procedure codes D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393 and D2394, the reimbursement determinations are based on the total number of different surfaces restored, not to exceed the total number of surfaces characteristic of that tooth, and no surface shall be billed twice. Reimbursement is not based on the total number of restorations placed. For example if a buccal, occlusal and lingual resin restoration were placed in a posterior tooth, the correct billing would be BOL D2393 and **not** D2391 times 3.

Crowns, Single Restorations Only

Medicaid covers crowns, post & cores, and core buildups **only** following root canal therapy (D3310, D3320, D3330) which must qualify for Medicaid coverage. Effective July 1, 2003, crowns (**excluding stainless steel or resin crowns**), core buildups and post & cores are limited to the permanent teeth on eligible recipients age 15 years or older following root canal therapy. Limited to one per tooth per lifetime. Crowns, post & cores, and buildups on 3rd molars are not covered, with the exception noted below:

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NOTE:

Exception: When the second molar is missing and the third molar has moved into the second molar's space and is functioning tooth, the provider must submit a radiograph with a prior authorization request for consideration of payment.

Effective April 1, 2006, permanent, stainless steel or resin crowns are limited to 6 per date of service individually or in combination when performed in an office setting. These procedure codes include D2740, D2750, D2751, D2752, D2792, D2930, D2931, and D2932.

Amalgam or resin restorations or sedative fillings are not authorized on teeth being crowned. Codes D2940, D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393 and D2394 are non-covered services for a tooth eligible for a crown (D2740-D2792). Codes D2950, D2951, D2952, D2953, D2954 and D2957 are covered services for a tooth eligible for a crown (D2740-D2792).

Effective January 1, 2005 reimbursement fees for crown (D2740 – D2792) procedures include any: crown follow up appointments, pre and post radiographs, equilibration, or recementation within 6 months of insertion.

Procedure Code	***Description of Procedure***	***Prior Authorization Required***
D2740	Crown – porcelain/ceramic substrate (limited to age 15 or older, on endodontically treated teeth only)	No*
D2750	Crown – porcelain fused to high noble metal (limited to age 15 or older, on endodontically treated teeth only)	No*
D2751	Crown – porcelain fused to predominantly base metal (limited to age 15 or older, on endodontically treated teeth only)	No*
D2752	Crown – porcelain fused to noble metal (limited to age 15 or older, on endodontically treated teeth only)	No*
D2791	Crown – full cast predominantly base metal (limited to age 15 or older, on endodontically treated teeth only)	No*
D2792	Crown – full cast noble metal (limited to age 15 or older, on endodontically treated teeth only)	No*

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Added: Information is available…title, "Dental Forms."

***No prior authorization is required for crowns, core buildups, or post & cores. If there is no root canal in Medicaid's history, send an Administrative Review Form via the Interactive Web Portal. Support documentation should include a diagnostic postoperative periapical x-ray after crown is seated showing completed root canal and crown (bitewings are not acceptable). Information is available on the Agency website which provides detailed directions for submitting a Dental Administrative Review form electronically via the Provider Interactive Web Portal. Visit www.medicaid.alabama.gov. Select the *Programs* tab, *Dental Program*, and look under the title, "*Dental Forms*."**

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NOTE:

Providers will be reimbursed for only one code per tooth per lifetime for procedures D2740, D2750, D2751, D2752, D2791 and D2792.

Incomplete Procedures

Effective July 1, 2003 for multiple appointment procedures, payment will be made to the provider that started the procedure. **Documentation that several attempts were made to complete the procedure** (i.e. phone calls, certified letters) must be supported in the medical record. If no documentation can be provided to support multiple attempts were made to complete the procedure, the starting provider will not be reimbursed. **Billing should only occur after documentation of failed attempts is complete.** If the recipient is treated by a subsequent provider for the same procedure, same tooth, the services are considered non-covered.

Other Restorative Services

Procedure Code	***Description of Procedure***	***Prior Authorization Required***
D2920	Re-cement crown - Limit 2 per lifetime per tooth None allowed within the first six months of placement	No
D2930	Prefabricated stainless steel crown, primary tooth The following are indications for placement of stainless steel crowns (prefabricated crown forms) for fitting on individual teeth: For the restoration of primary and permanent teeth with caries, cervical decalcification, and/or development defects (hypoplasia and hypocalcification) When the failure of other restorative materials is likely with interproximal caries extended beyond line angles Following pulpotomy or Pulpectomy For restoring a primary tooth being used as an abutment for a space maintainer, or For restoring fractured teeth when the tooth cannot be restored with other restorative materials. Limited to two per tooth per lifetime	No
D2931	Prefabricated stainless steel crown, permanent tooth.	No
D2932	Prefabricated resin crown are authorized on primary or permanent teeth. **Allowable on anterior teeth only.**	No
D2940	Sedative fillings - temporary restoration intended to relieve pain. Not to be used as liners or bases under restorations. Not allowable with: amalgam or resin restoration, endodontically treated teeth, core buildups, posts and cores, done on same tooth, same DOS.	No

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Procedure Code	*Description of Procedure*	*Prior Authorization Required*
	Non-covered for teeth A-T age 7 and older. Limit one per tooth.	
D2950	Core buildup, including any pins. Covered for permanent teeth that have had endodontic treatment. Not covered on primary teeth. **Limited to age 15 or older** Not allowable on the same tooth with: • Amalgam or resins (D2140 – D2394) • Posts & Cores (D2952, D2953, D2954, D2957) Sedative (temporary) fillings (D2940) Pins (D2951)	No
D2951	Pin retention – per tooth in addition to restoration. Not allowable with D2950	No
D2952	Post and core in addition to crown, indirectly fabricated Not billable with D2950 **Limited to age 15 or older** Posts which extend less than one-half the distance of the root length measured from the cementoenamel junction to the anatomic root apex are not covered.	No
D2953	Each additional indirectly fabricated post – same tooth - (maximum of 2) Not billable with D2950 **Limited to age 15 or older** Posts which extend less than one-half the distance of the root length measured from the cementoenamel junction to the anatomic root apex are not covered.	No
D2954	Prefabricated post and core in addition to crown - (maximum of 1) Not billable with D2950 **Limited to age 15 or older** Posts which extend less than one-half the distance of the root length measured from the cementoenamel junction to the anatomic root apex are not covered.	No
D2957	Each additional prefabricated post – same tooth – (maximum of 1) Not billable with D2950 **Limited to age 15 or older** Posts which extend less than one-half the distance of the root length measured from the cementoenamel junction to the anatomic root apex are not covered.	No

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Effective April 1, 2006, core buildups (D2950) and post and cores (D2952, D2954) are limited to 6 per date of service individually or in combination when performed in an office setting.

Effective July 1, 2003, the following codes require at a **minimum a diagnostic pre-treatment periapical radiograph** be taken and maintained on file: D2740, D2750, D2751, D2752, D2791, D2792, D2952, D2953, D2954, and D2957.

Effective July 1, 2004, to qualify for coverage: posts must be radiographically visible and distinct from the obturation material. "So-called Posts" made in the office solely by flowing or compacting materials into the canal(s), such as resins, polymers, acrylics, amalgams, etc., are not covered. In order to qualify for coverage, posts must be fitted and cemented within the prepared root canal, and be attached to the core in order to retain the core. Posts which do not meet criteria for coverage will not be covered as core buildups. Core buildups and posts & cores are only covered on teeth which are receiving crowns and are limited to once per eligible tooth per lifetime.

Endodontics

Pulp Capping

Bases, liners, and sedative fillings do not qualify as pulp caps. Pulp caps without a protective restoration are not covered. There must be radiographic evidence of deep caries.

Procedure Code	***Description of Procedure***	***Prior Authorization Required***
D3110	Pulp cap, Direct (excluding final restoration) Covered for permanent teeth only. Pulp cap must cover a documented exposed pulp. **Limit one per tooth**	No
D3120	Pulp cap, Indirect (excluding final restoration) Covered for permanent teeth only. Effective January 1, 2005, indirect pulp caps are only covered for documented treatment of **deep** carious lesions near the dental pulp with a protective dressing over the remaining carious dentin to prevent operative pulp exposure. Radiographs must support the indication of deep caries. **Limit one per tooth per lifetime.**	No

Pulpotomy/Pulpectomy

Only the single most appropriate endodontic code should be billed. It is not appropriate to bill pulpotomy/pulpectomy (D3220) and pulpal therapy on primary teeth (D3230 or D3240) for the same tooth. D3220 must not be billed with D3310, D3320, D3330 or D3332 for the same tooth, as these four codes already include a pulpotomy or pulpectomy. **Pulpotomies are not covered for permanent teeth effective July 1, 2003.**

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Effective April 1, 2006, the following limitations apply for endodontic procedures when performed in an office setting. Pulpotomies (D3220) and Pulpal Therapy (D3230, D3240) are limited to 6 per date of service individually or in combination.

Procedure Code	*Description of Procedure*	*Prior Authorization Required*
D3220	Therapeutic pulpotomy **Covered for primary teeth only, excluding final restoration**	No

Primary Endodontics

Procedure Code	*Description of Procedure*	*Prior Authorization Required*
D3230	Pulpal therapy, anterior primary tooth	No
D3240	Pulpal therapy, posterior primary tooth	No

D3230 and D3240 would be covered **ONLY** when all of the following documented indications exist: the primary tooth is restorable and must be saved until the permanent tooth erupts, **the pulp is non-vital** with no radiographic signs of internal or external root resorption, is present. **These procedures requiring a complete pulpectomy, require diagnostic pre-treatment and post-treatment periapical films be taken and maintained on file.** POST-TREATMENT PERIAPICAL FILMS MUST BE TAKEN ON THE SAME DATE THE PULPECTOMY WAS COMPLETED. Radiographs are included as part of the procedure (D3230 & D3240) and are not billable to Medicaid or the recipient. These radiographs must show successful filling of canals with a resorbable filling material without gross overextension or underfilling. Follow up evaluations with radiographs to assess condition, including possible breakdown of supporting tissues, must also be documented.

Endodontics on Permanent Teeth

Root canal therapy for permanent teeth includes diagnosis, extirpation of the pulp, shaping and enlarging the canals, temporary fillings, filling and obliteration of root canals(s), progress radiographs, including a root canal fill radiograph and follow-up care. Endodontics on third molars is not a covered procedure. Effective April 1, 2006, root canal treatment on anterior (D3310) and premolars (D3320) are limited to 6 per date of service individually or in combination when performed in an office setting. Molar root canals (D3330) are limited to 2 per date of service in an office setting. One molar root canal can be performed with 3 anterior or premolar root canal procedures in an office setting.

The following codes are covered only on permanent teeth and require a diagnostic pre-treatment and post-treatment periapical radiograph be taken and maintained on file: D3310, D3320, D3330, D3351, D3410, and D3430. Endodontics (D3310 – D3430) are **only** covered when there are documented tests performed (electrical pulp tests, thermal, percussion, palpation) in the

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record consistent with radiographic findings and symptoms which support a documented pulpal pathology diagnosis of an irreversible nature on a specific restorable tooth and one of the following procedures are indicated: D3310, D3320, or D3330. When reviewing a radiograph, canals must be filled at approximately 1mm or less from the apex of the root and have no voids in material. There should be a sealing material between the root canal filling material and restorative material.

Intentional endodontics performed for reasons other than documented irreversible pulpal pathology of a specific restorable tooth, such as, but not limited to: prosthetics, bleaching, orthodontics, non-covered periodontal or oral surgery procedures, pain of undetermined origin, preference of the recipient or provider, etc. are not covered and are subject to recoupment.

Procedure Code	***Description of Procedure***	***Prior Authorization Required***
D3310	Anterior, excluding final restoration (age 6 or older)	No
D3320	Bicuspid, excluding final restoration (age 9 or older)	No
D3330	Molar, excluding final restoration (age 6 or older)	No
D3332	Incomplete endodontic therapy on permanent teeth due to the tooth becoming inoperable or unrestorable due to a fracture or removal of gross decay must be submitted for a prior authorization prior to payment.	Yes
D3351	Apexification, per treatment visit **(nonvital permanent teeth only)** This procedure is only covered after apical closure is obtained and demonstrated with a postoperative periapical radiograph maintained in the record. This postoperative film must be taken after apexification is completed but before canal obturation is performed. Usually several treatments are required. Treatment performed in less than 180 days after apexification with Calcium Hydroxide is not covered. When using Mineral Trioxide Aggregate (MTA) for apexification, the 180 days does not apply.	No

Periapical Services

Procedure Code	***Description of Procedure***	***Prior Authorization Required***
D3410	Apicoectomy - Anterior, per tooth - Limit 1 per tooth per lifetime	Yes
D3430	Retrograde filling - **Limit 1 per tooth per lifetime** Covered only in conjunction with D3410 on anterior teeth	Yes

D3230, D3240, D3310, D3320, D3330, D3410 and D3430: **require diagnostic pre-treatment and post-treatment periapical films be taken and maintained on file**. In addition, follow up evaluations with radiographs to assess condition, including possible breakdown of supporting tissues, must also be documented.

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Prior Authorization requests for D3410 and D3430 require a postoperative endodontic periapical film with the history and examination findings to include: symptoms, periodontal probings, palpation, percussion, mobility, presence of swelling or sinus tract, etc. and an **explanation of why re-treatment is not being considered.**

Periodontics

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

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

Procedure Code	***Description of Procedure***	***Prior Authorization Required***
D4341	Periodontal scaling and root planning, per quadrant Prior authorization for scaling and root planning requires documentation of pocket depths as follows: • Patients **over** 12 years old must have a generalized pocket depth **greater than 4 mm**, with demonstrable radiographic evidence of generalized periodontitis. (This procedure involves instrumentation of the crown and root surfaces of the teeth to remove plaque from these surfaces.) • For patients **under** 12 years old, this procedure is ordinarily not indicated unless some unusual circumstance requires a more in-depth review and documentation (for example, familial juvenile periodontitis.) • This procedure will not be authorized for treatment of pseudopockets. • This procedure requires that radiographs (posterior bitewings and anterior periapicals or bitewings) and complete periodontal charting (including probing depths, free gingival margins in relation to CEJs, etc.) be provided with the request. A limit of no more than **two quadrants** of scaling and root planning will be permitted for each date of service, except for patients treated as inpatient/outpatient hospitalization cases. This procedure not allowed for same quadrant, same date of service with: D1110, D1120, D1201, D1205, D4355, or D4910.	Yes
D4355	Full mouth debridement Covered only when subgingival and/or supragingival plaque and calculus obstruct the ability to perform a comprehensive oral evaluation. This is a preliminary procedure and does not rule out the need for other procedures. This procedure requires that appropriate radiographs (bitewings, periapicals) be sent with the request. Clinical photographs/images may be required upon request. This procedure is not allowed on the same date of service or within 6 months of scaling and root planning. If prior approved, this procedure must be performed before a comprehensive evaluation is done.	Yes

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Procedure Code	*Description of Procedure*	*Prior Authorization Required*
	This procedure is not allowed on same date of service or within 6 months of: D1110, D1120, D4341, or D4910. Difficult prophylaxis should be reported as a "routine" dental prophy (D1120, D1110).	
D4910	Periodontal maintenance procedures Prior authorization for Periodontal/Special Maintenance following active therapy (D4341) requires the following information: • A clinical description of the service • Procedure recommendations • X-rays • Complete periodontal charting (probing depths, free gingival margins in relation to CEJs) • Current CDT procedure code • The number of units or visits This procedure is not allowed on same date of service with: D1110, D1120, D4341 or D4355	Yes

Prosthetics

Prosthetic treatment requires prior authorization and are covered only for closure of a space created by the removal of a lesion or due to congenital defects (permanent tooth congenitally missing).

Procedure Code	*Description of Procedure*	*Prior Authorization Required*
D5110	Complete denture - maxillary	Yes
D5120	Complete denture - mandibular	Yes
D5213	Maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests, and teeth	Yes
D5214	Mandibular partial denture – case metal framework with resin denture bases (including any conventional clasps, rests, and teeth)	Yes
D5282	Removable unilateral partial denture – Maxillary - one piece cast metal (including clasps and teeth)	Yes
D5283	Removable unilateral partial denture – Mandibular – one piece cast metal (including clasp and teeth)	Yes
D6212	Pontic – cast noble metal	Yes
D6240	Pontic – porcelain fused to high noble metal	Yes
D6241	Ponitc – porcelain fused to predominantly base metal	Yes

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D6242	Pontic – porcelain fused to noble metal	Yes
D6245	Pontic – porcelain/ceramic	Yes
D6740	Retainer crown – porcelain/ceramic	Yes
D6750	Retainer crown - porcelain fused to high noble metal	Yes
D6751	Retainer crown - porcelain fused to predominantly base metal	Yes
D6752	Retainer crown - porcelain fused to noble metal	Yes
D6792	Retainer crown – full cast noble metal	Yes

Oral Surgery

Extractions

Extractions include local anesthesia, (infiltration **and/or** nerve block), aveoloplasty, suturing if needed and routine postoperative care. Extractions of exfoliating primary teeth will not be covered unless there is a valid indication (e.g. pain, eruption interference, abscess, etc.) documented in the dental record.

Procedure Code	***Description of Procedure***	***Prior Authorization Required***
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	No

NOTE:

Payment for extraction is for the complete removal of tooth (clinical crown and roots). Partial extraction of a tooth is subject to recoupment.

Surgical Extractions

Effective July 1, 2003, surgical extractions include and require documentation of local anesthesia, alveoloplasty, mucoperiosteal flap elevation, osseous removal, sectioning and removal of tooth structure, sutures, and routine postoperative care. Radiographs are required with PA request for procedure codes D7240 and D7241. D7241 requires a report by tooth number of **actual unusual surgical complication(s)**. The following codes are only covered for permanent teeth: D7210, D7220, D7230, D7240, D7241, and D7250. **Exception: Ankylosed or impacted primary teeth may be submitted by report with radiographs.** To be reimbursed, providers must send a diagnostic x-ray of primary tooth, report and completed claim form directly to: Alabama Medicaid Agency ATTN: Dental Program, 501 Dexter Ave, P.O. Box 5624 Montgomery, AL 36130-5624.

Payment for extraction is based on documentation of medical necessity. Refer to Section 13.5.

Extractions due to crowding to facilitate orthodontics are not covered unless the orthodontics is covered meeting Medicaid criteria.

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Procedure Code	*Description of Procedure*	*Prior Authorization Required*
D7210	Surgical removal of erupted tooth, requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth. Requires documentation of cutting of both gingival and bone, removal of tooth structure, and closure. **Covered for permanent teeth only**	No
D7220	Removal of impacted tooth – soft tissue occlusal surface must be covered by soft tissue, requires documentation of mucoperiosteal flap elevation. **Covered for permanent teeth only.**	No
D7230	Removal of impacted tooth – partially bony a portion of the crown must be covered by bone, requires documentation of mucoperiosteal flap elevation and bone removal. **Covered for permanent teeth only.**	No
D7240	Removal of impacted tooth – completely bony **most or all of the crown must be covered by bone,** requires documentation of mucoperiosteal flap and bone removal. **Covered for permanent teeth only.**	Yes
D7241	Removal of impacted tooth – completely bony, with unusual surgical complications most or all of the crown must be covered by bone, requires documentation of mucoperiosteal flap and bone removal. Covered for **actual** complications only by report. **Covered for permanent teeth only.**	Yes
D7250	Surgical removal of residual tooth roots must require documentation of cutting of both soft tissue and bone and removal of tooth structure. Not covered if a portion or all of crown is present. **Covered for permanent teeth only.**	No

Procedures: D7210, D7220, D7230, D7240, D7250 requirements listed above (i.e. flap, bone removal, sectioning, etc.) must be documented in the dental record to be covered.

Other Surgical Procedures Applied To Teeth

Procedure Code	*Description of Procedure*	*Prior Authorization Required*
D7270	Tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth and/or alveolus. This fee includes any composite or bonding attachment to evulsed or displaced tooth and	No

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Procedure Code	*Description of Procedure*	*Prior Authorization Required*
	adjacent teeth as well as any brackets, wire or line used. **Covered for permanent teeth only.**	
D7280	Surgical exposure of impacted or unerupted tooth to aid eruption	No
D7285	Biopsy of oral tissue, hard (bone, tooth)	No
D7286	Biopsy of oral tissue, soft (all others)	No

Removal of Tumors, Cysts, and Neoplasms

Procedure Code	**Description of Procedure**	*Prior Authorization Required*
D7410	Excision of benign lesion up to 1.25 cm	No
D7450	Removal of odontogenic cyst or tumor, lesion diameter up to 1.25 cm	No
D7451	Removal of odontogenic cyst or tumor, lesion diameter greater than 1.25 cm	No
D7460	Removal of non-odontogenic cyst or tumor, lesion diameter up to 1.25 cm	No
D7461	Removal of non-odontogenic cyst or tumor, lesion diameter greater than 1.25 cm	No

Excision of Bone Tissue

Procedure Code	*Description of Procedure*	*Prior Authorization Required*
D7471	Removal of exostosis – per site	No
D7510	Incision and drainage of abscess, intraoral soft tissue. Requires documentation of incision through mucosa, area of incision, presence of any purulence from the abscess, use of any drain or sutures. Not allowed in same site as a surgical tooth extraction. Incisions through the gingival sulcus are not covered.	No
D7520	Incision and drainage of abscess, extraoral soft tissue. Requires documentation of incision through skin and area of incision, type of drain (if any) and sutures (if closed)	No

Treatment of Fractures - Simple

Procedure Code	*Description of Procedure*	*Prior Authorization Required*
D7610	Maxilla - open reduction (teeth immobilized if present)	No
D7620	Maxilla - closed reduction (teeth immobilized if present)	No

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Procedure Code	*Description of Procedure*	*Prior Authorization Required*
D7630	Mandible - open reduction (teeth immobilized if present)	No
D7640	Mandible - closed reduction (teeth immobilized if present)	No

Reduction of Dislocation - Management of Other Temporomandibular Joint Dysfunctions

Procedure Code	*Description of Procedure*	*Prior Authorization Required*
D7820	Closed reduction of dislocation	No

Other Repair Procedures

Excision of hyperplastic tissue (D7970) requires:

- Medical documentation, that the hyperplasia is drug-induced
- Possible oral images/photographs (if required by Medicaid)

Procedure Code	*Description of Procedure*	*Prior Authorization Required*
D7911	Complicated suture, up to 5 cm. **Excludes** closure of surgical incision reconstruction requiring delicate handling of tissue and wide undermining for meticulous closure.	No
D7961	Labial frenectomy (frenulectomy), separate procedure	No
D7962	Lingual frenectomy (frenulectomy)	No
D7970	Excision of hyperplastic tissue; per arch (covered for drug-induced cases only)	Yes
D7971	Excision of pericoronal gingival. Covered for partially erupted or impacted teeth only. Use for operculectomy. Not allowed for crown lengthening or gingivectomy.	No

Orthodontics

Orthodontic services require prior authorization. Orthodontic services must be requested through a multidisciplinary clinic administered by Alabama Children's Rehabilitation Service or another qualified clinic enrolled as a contract vendor in the Medicaid Dental Program. See Section 13.5.1 of this chapter entitled *Orthodontic Services* for more details.

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Adjunctive General Services

Procedure Code	*Description of Procedure*	*Prior Authorization Required*
D9110	Palliative (emergency) treatment of minor dental pain. This procedure requires documentation in the record of: symptoms, findings, tests (if performed), radiographs if taken, diagnosis, and description of emergency treatment. Cannot be billed with the following definitive or emergency procedures: D0210, D0350, D0470, D1110 through D7970, D7971, D9220 and D9610. This is a specific code and must not be used to bill for any procedure that has its own unique code, even if the most appropriate code is not covered. Always bill the most appropriate and current CDT code **Limit one per visit.**	No

Procedures

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

Anesthesia

Procedure Code	*Description of Procedure*	*Prior Authorization Required*
D9222	General anesthesia – first 15 minutes; maximum of 1 unit per date of service.	No
D9223	General anesthesia – each additional 15 minute increment; maximum of 1 unit per date of service. **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 intellectual disability, a fearful, extremely nervous/anxious or obstreperous patient, or an extremely uncooperative patient. Effective April 1, 2004, documentation of medical necessity, written informed consent, and nitrous oxide dosage (% nitrous oxide/oxygen and/or flow rate, duration of the procedure, post treatment oxygenation procedure and condition of the patient upon discharge), **must be** in the medical record. The provider or recipient's desire to use this procedure, by itself, does not qualify it as medically necessary.	No
D9239	Intravenous sedation/analgesia – first 15 minute increment; maximum of 1 unit per date of service. **Requires current state board IV or GA permit**	
D9243	Intravenous sedation/analgesia – 15 minute increment; maximum of 2 units per date of service. **Requires current state board IV or GA permit**	No
D1999	In-office general anesthesia for providers enrolled with Specialty 279 – Dental Anesthesiology	Yes

Added: D9239 Intravenous sedation…or GA permit

Added: D1999 In-office…279-Dental Anesthesiology

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Drugs

Procedure Code	*Description of Procedure*	*Prior Authorization Required*
D9610	Therapeutic parental drug, single administration, by report billable only when no definitive treatment rendered in same visit	Yes
D9612	Therapeutic parenteral drugs, two or more administrations, different medications billable only when no definitive treatment rendered in same visit	Yes

Periodicity Schedule

NOTE:

The periodicity schedule below is only a guideline to help practitioners make clinical decisions concerning preventive oral health interventions, including anticipatory guidance and preventive counseling, for infants, children, and adolescents. Please refer to policy and procedures within "Chapter 13 Dental" governing reimbursement for dental procedures.

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ALABAMA MEDICAID'S EPSDT PERIODICITY SCHEDULE

	Infancy							Early Childhood						Middle Childhood						Adolescence									
AGE	Newborn[1]	3-5 days[2]	By 1 Mo	2 Mo	4 Mo	6 Mos	9 Mos	12 Mos	18 Mos	24 Mos	30 Mos	3 Yrs	4 Yrs	5 Yrs	6 Yrs	7 Yrs	8 Yrs	9 Yrs	10 Yrs	11 Yrs	12 Yrs	13 Yrs	14 Yrs	15 Yrs	16 Yrs	17 Yrs	18 Yrs	19 Yrs	20 Yrs
Clinical oral examination[1,2]						←	→	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Assess oral growth and development[3]						←	→	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Caries-risk assessment[4]						←	→	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Radiographic assessment[5]						←	→	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Prophylaxis and topical fluoride treatment[4,5]						←	→	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	O	O	O	O	O
Fluoride supplementation[6,7]						←	→	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Anticipatory guidance/counseling[8]						←	→	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Oral hygiene counseling[9]						←	→	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Dietary counseling[10]						←	→	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Injury prevention counseling[11]						←	→	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Counseling for nonnutritive habits[12]						←	→	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Counseling for speech/language development[13]								X	X	X	X	X	X	X	X														
Alcohol and drug use assessment[13]						←	→									X	X	X	X	X	X	X	X	X	X	X	X	X	X
Counseling for intraoral/perioral piercing																X	X	X	X	X	X	X	X	X	X	X	X	X	X
Assessment and treatment of developing malocclusion						←	→		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Assessment for pita and fissure sealants[14]								X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Assessment and/or removal of third molars																						X	X	X	X	X	X	X	X
Transition to adult dental care																					←								→

NOTES:

X To be performed
O Perform when necessary
←→ Perform within indicated timeframe

1 First examination at the eruption of the first tooth and no later than 12 months. Repeat every 6 months or as indicated by child's risk status/susceptibility to disease.
2 Includes assessment of pathology and injuries.
3 By clinical examination.
4 Must be repeated regularly and frequently to maximize effectiveness.
5 Timing, selection, and frequency determined by child's history, clinical findings, and susceptibility to oral disease.
6 Consider when systemic fluoride exposure is suboptimal.
7 Up to at least 16 years of age.
8 Appropriate discussion and counseling should be an integral part of each visit.
9 Initially, responsibility of parent; as child develops, jointly with parent; then, when indicated, only child.
10 At every appointment; initially discuss appropriate feeding practices, then the role of refined carbohydrates and frequency of snacking in caries development and child hood obesity.
11 Initially play objects, pacifiers, car seats; then learning to walk, sports and routine playing.
12 At first discuss the need for additional sucking: digits vs pacifiers; then the need to wean from the habit before malocclusion or skeletal dysplasia occurs. For school-aged children and adolescent patients, counsel regarding any existing habits such as fingernail biting, clenching, or bruxism.
13 Referral to a Pediatrician, if necessary.
14 For caries-susceptible primary molars, permanent molars, premolars, and anterior teeth with deep pits and fissures; placed as soon as possible after eruption.

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Tooth Numbers and Letters

- Enter the tooth number or letter for the appropriate tooth. Use the letters and/or numbers shown on the dental chart. Additional tooth designations are listed below. Insert these in the “Tooth # or Letter” block on the claim when indicated.
- Tooth Numbers should include for Permanent dentition: 01 through 32
- Tooth Numbers should include for Primary dentition: A through T
- Supernumerary are as follows:

A supernumerary tooth for Permanent Dentition (Tooth numbers 01-32) would have 50 added to its tooth number. Therefore if a patient had an extra tooth number 30 it would be coded as tooth number '80' (30 + 50 = 80). Valid numbers would be 51 through 82.

A supernumerary tooth for Primary Dentition (Tooth numbers “A” through “T”) would place an 'S' after the tooth code. If a patient had an extra 'A' tooth, it would be coded 'AS'. Valid letters would be ‘AS’ through ‘TS’.

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

Code	***Designation***	***Code***	***Designation***
00	Full mouth	30	Lower Left Quadrant
01	Upper Arch	40	Lower Right Quadrant
02	Lower Arch		
10	Upper Right Quadrant	L	Left
20	Upper Left Quadrant	R	Right

Surface

Please bill the single most appropriate surface involved using the following abbreviations:

Code	***Designation***	***Code***	***Designation***
B	Buccal; Labial	L	Lingual
D	Distal	M	Mesial
I	Incisal	O	Occlusal
F	Facial; Labial		

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

2 Surfaces			***3 Surfaces***				***4 Surfaces***		***5 Surfaces***	
MO DB MB DL	IF IL DI MI	ML OB DO OL	MOD MOB MOL MBD	IFL MIL DIL MLD	BOL DOB DOL	MID MIF DIF	MODB MODL MOBL MIDF	MIFL DIFL MIDL	*MODBL* *MIDBL*	*MODFL* *MIDFL*

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13.8.3 Place of Service Codes

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

Place of Service Codes	*Place of Service*
11	Dental office
15	Mobile Clinic
19	Outpatient Hospital
21	Inpatient hospital
22	Outpatient hospital
31	Skilled nursing facility or nursing facility

NOTE:

Place of service codes 31 requires prior authorization before delivery of the service, unless recipient is less than 5 years old. Refer to section 13.8.2 for additional information on places of service that require prior authorization.

13.8.4 Required Attachments

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

- Claims With Third Party Denials

NOTE:

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

Refer to Chapter 5 Filing Claims, Section 5.8, Required Attachments, for more information on attachments

13.9 For More Information

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

Resource	Where to Find It
ADA Dental Claim Form Instructions	Chapter 5
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N
Dental Prior Authorization Form	Chapter 5
Medical Necessity/Medical Necessary Care	Chapter 7

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14

14 Durable Medical Equipment (DME), Supplies, Appliances, Prosthetics, Orthotics and Pedorthics (POP)

Medicaid authorizes DME, supplies, appliances, and POP to Medicaid recipients of any age living at home. Participating providers (also referred to as "all providers mentioned in this chapter" or "provider") are those Home Health Agencies, pharmacies, DME, supply, appliance and POP suppliers contracted with Medicaid for this program. A provider of these benefits must ensure the following:

- The DME, supplies, appliances, and POP are for medical therapeutic purposes.
- The items will minimize the necessity for hospitalization, nursing facility, or other institutional care.

The prescriber is responsible for ordering the items in connection with his or her plan of treatment. The prescriber must be a licensed, active, Alabama Medicaid provider. The provider is responsible for delivering and setting up the equipment as well as educating the recipient in the use of the DME.

Prior Authorization (PA) requests for coverage of DME must be received by Medicaid's Fiscal Agent within 30 days after the equipment is dispensed. (See section 14.3.1 Authorization for Durable Medical Equipment)

NOTE:

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

Fee Schedule

DME Reimbursement rates and benefit limits for covered equipment and supplies are published on Medicaid's website at the following link:
http://medicaid.alabama.gov/content/Gated/7.3G_Fee_Schedules.aspx

This DME Provider Manual is not an ALL INCLUSIVE DOCUMENT. Additional documentation may be needed upon request. The policy provisions for DME providers can be found in the *Alabama Medicaid Agency Administrative Code,* Chapter 13.

14.1 Enrollment

Medicaid's Fiscal Agent enrolls providers and issues provider contracts to applicants who meet the licensure or certification requirements of the state of Alabama, the Code of Federal Regulations, the Alabama Medicaid Agency Administrative Code, and the Alabama Medicaid Provider Manual. A copy of the approved Medicare enrollment application or Medicare enrollment letter 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

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misrepresentation might result in action ranging from denial of application to permanent exclusion.

Re-Validation

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

Application Changes Process

Providers must notify Medicaid's Fiscal Agent in writing of any changes to the information contained in its application at least 30 business days prior to making such changes. These changes may include, but are not limited to, changes in ownership or control, federal tax identification number, or business address changes.

Change of Ownership (CHOW) and Closures

Medicaid will mirror Medicare's Change of Ownership (CHOW) policy.
Refer to Chapter 19, Hospital for additional information on Change of Ownership.

National Provider Identifier (NPI) Type and Specialty

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

NOTE:

The 10-digit NPI is required when filing a claim.

DME providers are assigned a provider type of 25 (DME) and DME providers of Durable Medical Equipment/Oxygen are assigned a specialty of 250.

Effective August 1, 2014, Medicaid DME providers will enroll or re-validate as the following applicable provider specialties:

Specialty Name	Specialty Number	Contract Name(s)	Contract Start Date	Contract End Date
Durable Medical Equipment	250	DME		8/1/15 (for all contracts assigned prior to 8/1/14)
Prosthetic, Orthotics & Pedorthics	251	POP (adults ages 21-65	8/1/14	N/A
		YPOP (youth ages 0-20)		
Mastectomy Fitter	254	MSFIT	8/1/14	N/A
Therapeutic Shoe Fitter (TSFIT)	256	TSA: Therapeutic Shoe Fitter -Adult (ages 21-65)	8/1/14	N/A
		TSCE: Therapeutic Shoe Fitter -Child/Elderly (ages 0-20 and 66-999)		

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Provider Enrollment Process

New Enrollments

New providers enrolling on or after August 1, 2014 **must** select the applicable provider specialty (all that apply) during the initial enrollment process.

Re-validations

Currently enrolled providers **must** select the applicable specialty (all that apply) during the annual re-validation process.

NOTE:
Providers may select more than one provider specialty; however, the required license or certification documentation must be submitted during the enrollment or re-validation process. The provider can only be assigned the specialty for which the appropriate supporting documentation is provided.

A POP provider does not have to select the DME specialty if it is not appropriate for the services provided; however, POP providers must continue to meet all DME requirements detailed in this chapter. The federal statute considers providers of POP services as DME providers or suppliers.

Reimbursement

The use of the provider specialties will ensure that Medicaid is in compliance with the various Alabama licensing boards and only reimburses providers for services for which they are licensed to provide. Claims submitted on or after August 1, 2015 will deny when submitted by enrolled providers with no assigned provider specialty.

Additionally, providers will only be reimbursed for HCPCS codes included in their assigned provider specialty type.

DME Provider Enrollment Requirements

To participate in Medicaid providers shall have no felony convictions and no record of willful or grossly negligent noncompliance with Medicaid or Medicare regulations.

Physical Location Requirements

All providers must maintain a physical facility on an appropriate site in accordance with all applicable federal and state regulations and requirements.

a. The provider's business location must be accessible to the public, Medicaid recipients, recipient's representatives and Alabama Medicaid and its agents. (The location must not be in a gated community or other area where access is restricted.)

   - Location may be a "closed door" business, such as a pharmacy or supplier providing services only to recipients residing in a nursing home that complies with all applicable federal and state regulations or requirements. *"Closed door" businesses must comply with all applicable federal and state regulations and/or requirements.*

b. 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-only providers or providers described below.

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- Out-of state bordering DME providers, located within 30 miles of the border, may be enrolled as a regular Medicaid DME provider.
- Providers located more than 30-miles from the border may be enrolled only as follows:

  (1) for specialty equipment and supplies such as augmentative communication devices, automatic external defibrillators, high frequency chest wall oscillation air pulse generator systems which are not readily available in state; or

  (2) for supplies and equipment needed as the result of a transplant or unique treatment approved out of state as the result of an Early Periodic Screening, Diagnosis, and Treatment (EPSDT) referral or medical necessity. Suppliers will be enrolled by the Medicaid fiscal agent on a temporary basis for these situations.

Business Signs

All providers mentioned in this chapter must maintain a permanent visible sign in plain view and post hours of operation. If the provider's place of business is located within a building complex, the sign must be visible at the main entrance of the building and the hours can be posted at the entrance of the provider.

Business Telephone

A provider must maintain a primary business telephone listed under the name of the business in a local directory or a toll free number available through directory assistance. The primary business telephone number must be kept updated with the Agency's fiscal agent. The exclusive use of a beeper, answering machine, answering service or cell phone during posted business hours is prohibited.

Business Hours and Staffing

All providers mentioned in this chapter must remain open to the public for a minimum of **30** hours per week during normal business hours except physicians, physical and occupational therapists or a provider working with custom made orthotics and prosthetics.

Provider's location must be accessible and staffed during posted business hours of operation.

There must be at least one person present to conduct business at the physical location. This person must be knowledgeable about the DME supplies being sold at the location.

Supplies

Providers (as related to the provider specialty) must have DME, appliances or supply items stocked in the physical store location that are readily available to Medicaid recipients presenting prescriptions or orders for these items.

Providers must display, on the location's shelves, all non-custom items for which the provider will be submitting claims to Medicaid to request reimbursement.

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Displayed products must be clearly labeled, usable and readily accessible to a recipient who enters the provider location and presents a prescription or order for products (i.e. no expired products on the shelf and no products stored in bins on shelves).

Displayed items must be in the original manufacturer's packaging, when appropriate.

Shelf location for items must be labeled to include at minimum, the item's name.

Satellite Businesses and Multiple Locations

Satellite businesses affiliated with a provider are not covered under the provider contract; therefore, no reimbursement will be made to a provider doing business at a satellite location, however, a satellite may enroll with a separate NPI.

A provider with multiple store locations must have completed a provider application for each location. Each store location enrolled with Medicaid is assigned a unique Medicaid Identification Number.

License and Certification Requirements (Documents)

Providers should contact the applicable licensing or accreditation board(s) to determine the licensure requirements for each of the specialties. The appropriate documentation must be submitted during the Medicaid provider enrollment or re-validation process. If the appropriate licensure documentation is not submitted, the provider will not be assigned the selected specialty.

The provider must display, in an area accessible to recipients, customers and patients, all licenses, certificates and permits to operate.

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The chart below outlines the type of operation codes and services that can be provided by each specialty and the required license and accrediting board for each of the specialties.

Specialty Name	Specialty Number	Type of Operation Codes/Services	License/ Certification Required	License/Accreditation Board Website
DME	250	DME only "A", "B", "E" "S" and "T" HCPCS codes	HME license	Alabama Board of Home Medical Equipment (HME) Service Providers http://www.homemed.alabama.gov
Prosthetic, Orthotics & Prosthesis (POP/YPOP)	251	Prosthetic, Orthotic & Pedorthic (POP) Services only custom fabricated devices only	O&P facility license	Alabama State Board of Prosthetists and Orthotists http://www.apob.alabama.gov
Mastectomy Fitter (MSFIT)	254	Mastectomy Fitters "L" HCPCS codes (specified)	Mastectomy Fitter (MSF) license	Alabama State Board of Prosthetists and Orthotists http://www.apob.alabama.gov
		HME providers using prefabricated or off-the-shelf orthoses "L" HCPCS codes	MSF **and** HME licenses	
Therapeutic Shoe Fitter (TSFIT)	256	Therapeutic Shoe Fitters "A" HCPCS codes	Therapeutic Shoe Fitter (TSF) license	Alabama State Board of Prosthetists and Orthotists http://www.apob.alabama.gov

A copy of the following licenses or certifications must be provided, upon request, with the enrollment or re-validation processes:

License/Certifications Needed		Provider Exemptions
❒	Applicable State and Professional licenses	N/A
❒	Valid business license(s)	N/A
❒	Medicare Accreditation	Medicare exemptions apply
❒	Medicare Surety Bond (when applicable)	Medicare exemptions apply
❒	Medicaid Surety Bond (when applicable) Effective October 1, 2010, all participating providers are required to have a $50,000 Surety Bond for each NPI unless the provider meets an exemption. A provider who supplies Breast Prosthesis, Diabetic Shoes and Diabetic Shoe Inserts is **not** exempted.	A DME supplier who has been a Medicaid provider for five years or longer with no record of impropriety, and whose refund requests have been repaid as requested; or A government-operated DME, Prosthetics, Orthotics and Supplies (DMEPOS) provider; or A state-licensed orthotic and prosthetic personnel in private practice making custom-made orthotics and prosthetics; or Are physicians and non-physician practitioners, as defined in section 1842(b)(18) of the Social Security Act; or Are physical and occupational therapists in private practice; or Are providers who received $100,000 or less Medicaid payment in the past two calendar years and have been operating at the same location for at least two consecutive calendar years; or Are pharmacy providers; or Are phototherapy providers who only provide phototherapy services for infants; or Are Federally Qualified Health Centers.

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Effective June 5, 2015, out-of-state providers of home medical equipment and services, provided in accordance with state and federal laws and regulations, to Medicaid recipients are exempt from the HME law.

Pharmacy providers are required to be enrolled with Medicare. Pharmacy providers are **not** required to submit copies of Medicare or Medicaid Surety Bonds, Medicare Accreditation or HME License.

Prosthetic, Orthotic, and Pedorthic (POP) Providers

Basic level prosthetics, orthotics and pedorthics are covered benefits to Medicaid eligible recipients up to age 65 in a non-institutional and institutional setting. POP providers, **must**:

- be licensed by the Alabama Board of Prosthetics, Orthotics and Pedorthics,
- be an in-state provider ONLY, and
- meet the same requirements as other DME providers.

The provider is required to have a copy of their license(s) available for auditing purposes.

Consignment Closets

Medicaid does not provide coverage for Consignment Closets. Medicaid supports recipients exercising the freedom of choice option which is to use the provider of their choosing.

14.2 Benefits and Limitations

This section defines DME and provides Medicaid policy for supplying products.

Refer to Section 14.3 of this chapter for PA and Referral Requirements.

Refer to Chapter 3 of the Provider Manual, Verifying Recipient Eligibility, for general benefit information and limitations.

Refer to Chapter 7 of the Provider Manual, Understanding Your Rights and Responsibilities as a Provider, for general criteria about Medical Necessity and Medically Necessary Care.

Refer to the DME Fee Schedule on Medicaid's website for reimbursement rates and benefit limits for covered equipment and supplies at the following link: http://medicaid.alabama.gov/content/Gated/7.3G_Fee_Schedules.aspx

Benefit Limits

Medicaid covers items and supplies if the items and supplies are consistent with the implementation of the mandated Medicaid NCCI edits effective November 9, 2010. Refer to this link, https://www.medicaid.gov/medicaid/program-integrity/national-correct-coding-initiative-medicaid/index.html for more information regarding NCCI.

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- *Medically Unlikely Edits (MUEs) define for each HCPCS / CPT code the maximum units of service (UOS) that a provider would report under most circumstances for a single beneficiary on a single date of service.*

Exceeds Benefit Limit Requests

If the prescription or order to be paid by Medicaid exceeds the maximum benefit limit established by Medicaid, the provider must request an override or provider authorization request for the prescribed item(s).The requests for additional units with documentation justifying medical necessity must be submitted in compliance with Medicaid's override or PA request process. If the override or PA request is denied, the item(s) above the maximum benefit limit is not covered and the recipient may be charged as a cash recipient for the item(s) in excess of the maximum benefit limit.

NOTE:
A provider's failure or unwillingness to go through the process of obtaining an override or PA does not constitute a non-covered service.

14.2.1 Definitions

As defined by Medicaid, DME is equipment:

- that can stand repeated use;
- is primarily and customarily used to serve a medical purpose;
- generally is not useful to a person in the absence of an illness or injury; and
- is appropriate for use in the home.

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.

The cost of the item must not be disproportional 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.

Medicaid covers the purchase of DME items for long term use. Long term use is defined as the use of DME which exceeds six months. Medicaid covers the rental of DME items for six months or less.

Short Term Rental Policy

Standard DME items prescribed as medically necessary can be rented if needed on a short term basis. Short term is described as six months or less. Applicable procedure codes are indicated on the fee schedule with an RR for rental.

Medicaid does allow short term rentals of reclining wheelchairs for up to 3 months following a surgical procedure, other procedures or casting.

Medicaid payment for short term rental will be made when the following documentation is submitted:

1. Written order or prescription documenting an estimated period of time (number of months) that the medical equipment will be needed, and
2. Documentation that establishes medical necessity for the short term rental.

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Initial approval will consist of up to 90 days only. If the recipient needs the equipment beyond the initial 90 day period, written documentation (including an additional PA) must be submitted that demonstrates continued medical necessity.

If equipment continues to be medically necessary longer than six months, a capped rental to purchase will be established.

Capped Rental to Purchase (requires PA)

- Providers must submit a new PA request for the purchase of the item with previous rental payments deducted from the total purchase price of the item.
- Providers will submit their claims with the purchase price that Medicaid shows on the approved PA request for the purchase of the item.
- The requested dates of service on the new PA request for purchase of the item must not overlap with the dates of service on the PA request for the rental period of the item. Previous rental payments will be applied towards the total purchase price of the equipment.
- Reimbursement will not exceed the total purchase price of the equipment.

Providers should be aware of Medicaid policy regulating medical necessity for DME.

14.2.2 Non-covered Items and Services

Non-covered items and services include, but are not limited to:

- Items of a deluxe nature
- Replacement of usable equipment
- Items for use in hospitals, nursing facilities, or other institutions. However, DME items may be provided in nursing homes or other institutions for children through the EPSDT Program.
- Items for the patient or patient's caregiver's comfort or convenience
- Items not listed as covered by Medicaid
- Rental of equipment, with the following exceptions::
    - Rental for six months or less, or
    - Medicare crossovers, or
    - Certain intravenous therapy equipment, or
    - Short term use due to institutionalization, or
    - Short term use due to death of a recipient.
    - Negative Pressure Wound Pump are not covered in the home setting.

Medicaid recipients may be billed for non-covered items and items covered by non-contract providers.

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14.2.3 Method of Requesting DME, Supplies, Appliances and POP

Requirements for Placing the Initial Written Prescription/Order and the Required Face-to-Face Visit for Initiating Certain Medical Supplies, Equipment, and Appliances

In accordance with 42 C.F.R. § 440.70, the authorized practitioner who develops the recipient's written plan of care ("the ordering practitioner") is required to sign and place the initial prescription or order for certain medical supplies, equipment, and appliances. Subsequent written prescriptions/orders for refills, ancillary supplies, repairs or services, or re-certifications do not require the ordering practitioner's signature or an additional face-to-face visit.

Either an enrolled physician or one of the following authorized non-physician practitioners (NPP) may both conduct and document the clinical findings from the required face-to-face visit and write the initial written prescription or order for certain medical supplies, equipment, and appliances:

1. Certified registered nurse practitioners (CRNP) or clinical nurse specialists (CNS) working under a collaboration agreement under Alabama law with the ordering physician;
2. Physician assistants (PA) under the supervision of the ordering physician; or
3. Attending acute or post-acute physicians, if recipients are admitted to home health services immediately after discharge from an acute or post-acute stay.

The required face-to-face visit for the initial written prescription or order for certain medical supplies, equipment, and appliances must be related to the primary reason why the recipients require the certain medical supplies, equipment, and appliances and must occur no more than 6 months prior to the start of services. The required face-to-face visit may be conducted using telehealth systems.

The ordering practitioner is also required to review the recipient's written plan of care annually to determine the recipient's continued need for all medical supplies, equipment, and appliances.

Not all initial written prescriptions or orders for medical supplies, equipment, and appliances require a face-to-face visit be conducted. The face-to-face visit requirement is limited only to the certain medical supplies, equipment, and appliances that are also subject to a face-to-face requirement under the Medicare DME program as "Specific Covered Items" in 42 C.F.R. 410.38(g).

The following link from CMS provides a list of the DME codes for Specific Covered Items that are subject to the face-to-face visit requirements under the Medicare DME program: https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/Master-List

All wheelchair base codes (manual and power) require a face-to-face.

The ordering practitioner is also required to review the recipient's written plan of care annually to determine the recipient's continued need for all medical supplies, equipment, and appliances.

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DME providers are also required to maintain all such written or electronic documentation in the recipient's medical records.
Refer to Chapter 17—Home Health for more information on the requirements for placing the initial written prescription/order for home health services.

A written order or a signed prescription (as defined by the Medicare Program Integrity Manual Chapter 5) signed by the ordering practitioner is required for covered items. The order or prescription must be dated prior to or on the delivery date, unless a different effective date is clearly documented. Otherwise, the effective date is the date of the physician signature. An effective date that is handwritten on a prescription or order and differs from the date of the ordering practitioner's signature must be initialed and dated by the ordering practitioner to verify the effective date.

A valid prescription or order for diabetic supplies must include the recipient's name, date and signature of the provider, frequency of blood sugar testing, number of refills and a description of each item ordered. For example, a prescription or order cannot simply list, "diabetic supplies," but must **specify** the supplies (e.g., strips, lancets, glucometer).

- Verbal orders must be signed within 48 hours (two business days) of the order being issued. This prescription or order submitted to a participating provider determines medical necessity for covered items of supplies and appliances.
- Prescriptions cannot be written with indefinite, ninety-nine (99) refill date(s) or lifetime refills; these will **not** be accepted as a valid prescription.
- Automatic refills (the automatic refilling of a claim without recipient request prior to each fill) are not allowed. Claims found to be automatically refilled will be recouped.
- The length of need may be documented on the prescription or elsewhere in the medical documentation.
- The standard order/prescription must include the following elements:
    A. Beneficiary name
    B. Description of the item
    C. Quantity, if applicable
    D. Order date
    E. Treating practitioner name or National Provider Identifier (NPI)
    F. Treating practitioner signature.

Medicaid considers a prescription to be valid for the dispensing of supplies for a period of twelve months. After the twelve month period of time, the recipient must be reevaluated by the ordering practitioner to determine medical necessity for continued dispensing of medical supplies.

A prescription or order is considered to be outdated by Medicaid when it is presented to the provider or Medicaid's fiscal agent past 90 days from the date it was written.

EPSDT Referral

An EPSDT referral may be submitted as an order when written according to practice guidelines and state or federal law and must include the date and signature of the provider, the item(s) ordered and the recipient name. The EPSDT Referral Form may be

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considered the physician's order as long as the above noted guidelines are met. However, an EPSDT referral is **still required** as the referral provides the screening date and other additional information.

NOTE:

Signature Requirements for Referrals: Effective May 16, 2012:

For hard copy referrals, the printed, typed, or stamped name of the primary care physician with an original signature of the physician or designee is required. **Stamped or copied signatures will not be accepted**. For electronic referrals, provider certification is made via standardized electronic signature protocol.

Upon receipt of the prescription or order, the provider must:

- Verify Medicaid eligibility by using the recipient's Medicaid number using Medicaid's Automated Voice Response System, Medicaid's Web portal (interactive, real time), Provider Electronic Solutions or the Provider Assistance Center at Medicaid's Fiscal Agent. Recipient's eligibility must be verified on a monthly basis. Medicaid will not reimburse providers for items supplied to recipients in months where the recipient does not have eligibility.
- Obtain necessary referrals and PAs (EPSDT, etc.)
- Collect the appropriate copayment amount
- Furnish the covered item(s) as prescribed
- Retain the prescription or orders and all medical documentation in patient's file
- Submit the proper claim form to Medicaid's Fiscal Agent

By submitting the proper claim form, Medicaid expects the following:

- The provider agrees to accept as payment in full the amount paid by Medicaid for covered services.
- The provider (or provider's staff) advises each patient, prior to services being rendered, when Medicaid payment will not be accepted and the patient will be responsible for the bill.
- Documentation in patient chart that Medicaid payment will not be accepted and patient agrees to pay for services or equipment rendered.

The provider may not bill the recipient for an item for which an override or PA was denied due to provider error or failure and unwillingness to complete the process of obtaining an override or PA.

14.2.4 Warranty, Maintenance, Replacement, and Delivery

Warranty

All standard DME must have a warranty for a minimum of one year; this may include the manufacturer's warranty. If the provider supplies items that are not covered under a

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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. A statement of the warranty must be given to the recipient and the provider must keep a copy of the warranty for audit review by Medicaid. Medicaid may request a copy of the warranty. In the event the supplying provider does not honor the mandatory one year warranty and does not repair the items when needed, Medicaid may impose penalties, to include but not limited to deducting the total cost of the repairs from a check write of the supplying provider, recoupment of reimbursement paid to the provider for the equipment, or termination of the provider's contract.

Maintenance and Replacement

Medicaid covers repair and replacement of DME, supplies, appliances and POP. These services, in most cases, must be prior approved by Medicaid. The request for repair or replacement and appropriate documentation (includes PA when applicable) justifying the need for replacement must be submitted electronically to Medicaid's fiscal agent and kept in the recipient's file.

Requests for replacement or repair of items that are covered by Medicaid which are outside the normal benefit limits, due to damage beyond repair or other extenuating circumstances must be submitted to the DME Unit for review and consideration. Request for repair or replacement due to extenuating circumstances should be mailed to, Alabama Medicaid Agency, 501 Dexter Ave., DME Unit, Montgomery, AL, 36103.

Medicaid will not repair or replace items that are lost, destroyed, or damaged as a result of misuse, neglect, loss, or wrongful disposition of equipment by the recipient, the recipient's caregiver(s), or the provider. Requests for repair or replacement will be denied if such circumstances are confirmed. Payment for repair or replacement of items denied by Medicaid is the responsibility of the recipient. At a minimum, examples of misuse, neglect, loss or wrongful disposition by the recipient, recipient's caregiver, or the provider include, but are not limited to the following:

(a) Loss of item or related parts

(b) Selling or loaning item or related parts

(c) Damage due to weather

(d) Failure to store the items in a secure and covered area when not in use

(e) Loss, destruction or damage caused by the malicious, intentional or negligent acts

Repairs

K0739 repair or no routine service for durable medical equipment other than oxygen equipment requiring the skill of a technician, labor component, per 15 minutes

Effective January 1, 2015, the RB Modifier for Repair(s) for all wheelchair (manual or power) accessory procedure codes will allow a DME repair not exceeding $1,000 per day to bypass the need for PA. This may expedite the repair process which will be beneficial to Medicaid recipients and providers. This process will not apply to recipient's ages 0-20. This process will not override the current limitation audits for each of the procedure codes. For example, if the recipient has already received the yearly limit for a specific procedure code (e.g., 2 per calendar year), the provider will have to submit a PA for the repair even if it is less than the threshold amount of $1,000.

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Effective February 1, 2012, the allowable units for **K0739** are 12 per repair. However, providers must continue to submit justification with the PA request when submitting claims for more than four units. The request will be reviewed by Medicaid or its designee. The PA letter, in the Analyst Remarks section, will state the total units approved.

Replacement

E1399 - durable medical equipment, miscellaneous

Replacement parts are reimbursed based on the procedure code and fee schedule pricing. In situations where there are no procedure codes or fee schedule reimbursement for the replacement item(s), the provider must submit an itemized list of the needed items with invoice pricing for each item. Alabama Medicaid will reimburse these replacement items based on the provider's invoice price plus 20%. The reimbursement amount will be calculated based on the provider's **final invoice**, after all discounts have been applied.

No PA is needed for replacement of DME items that did not initially require a PA such as nebulizers.

Providers should submit their usual and customary charges for the service.

Replacement Equipment Due to Loss

Medicaid covers replacement items due to loss by disasters, fire, theft, etc. The provider must submit the appropriate documentation (fire report, police report, etc.) with the PA (if PA is required), and keep all related documentation in the recipient's file per Medicaid's record retention policy. Provider must file these claims with the appropriate procedure code and **Modifier CR**. The date of the report must be within 30 days of the date of loss or event. These claims will be monitored by Alabama Medicaid's DME Unit on a quarterly basis.

K0462- Temporary Replacement for Patient Owned Equipment Being Repaired

Reimbursement may be made for up to one month for a rental of patient owned equipment being repaired. When submitting a PA request, providers must submit the appropriate procedure code for the patient owned equipment being repaired. Medicaid will then establish the monthly rental at 80% of Medicare's allowable price for the code. If the temporary replacement is not needed for the entire month, the rental fee will be prorated on a daily basis. When submitting the claim to Medicaid's Fiscal Agent for payment, providers must bill using procedure code K0462 with the Medicaid established rate as it appears on the PA approval form.

Delivery

Upon furnishing DME, supplies, appliances and POP, the supplier must:

1. Obtain the recipient's signature or the signature of the recipient's designee. For the purposes of this chapter, designee is defined as: "Any person who can sign and accept the delivery on behalf of the recipient." The relationship of the designee should be noted on the delivery slip (i.e. spouse, power of attorney, etc.). The signature of the designee should be legible. If the signature is not legible, the name of the person should be printed on the delivery slip. This requirement applies to all dispensing methods. (Refer to Rule 560-X-1-.18: Provider/Recipient Signature on Claim Forms.)

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2. Document that the recipient was provided the necessary information and instructions on how to use Medicaid-covered items safely and effectively.

3. Retain all forms and documentation in the supplier's patient record.

Automatic Refills

Automatic refills are not permitted by the Medicaid Agency. Violations may result in unauthorized charges. The provider may be held liable, or Medicaid may recoup the unauthorized charges, or cancel the provider agreement.

Custom Made Items Ordered But Not Furnished

If custom made item(s) are ordered but not furnished, contact Alabama Medicaid's DME Unit prior to submitting a claim for the item(s). Failure to contact Medicaid (within one year of the date ordered) prior to claim submission may result in no payment and/or recoupment for work relating to item(s), items and/or materials paid to the provider.

NOTE:

For valid procedure codes and modifiers, refer to Appendix P, Durable Medicaid Equipment (DME) Procedure Codes and Modifiers.

For any procedure code paid at invoice plus 20%, such as E1399, the reimbursement amount will be calculated based on the provider's **final invoice,** after all discounts have been applied.

14.2.5 Walkers

E0140 Walker, with Trunk Support, Adjustable or Fixed Height, any Type (Specialty Walkers)

A specialty walker is a tool for disabled children with special needs who may require additional support to maintain balance or stability while walking. Walkers are height adjustable and should be set at a height that is comfortable for the user, but will allow the user to maintain a slight bend in their arms. The front two legs of the walker may or may not have wheels attached depending on the strength and abilities of the person using it.

Medicaid will cover specialty walkers for children under the age of 21 with an EPSDT referral.

Prior Authorization

E0140 requires prior authorization. (See Section 14.3.1 Authorization for Durable Medical Equipment.)

Documentation

The prescriber must prescribe the specialty walker as medically necessary. The medical documentation justifying the need must accompany the PA request. Documentation must also include an evaluation by the recipient's physician or a physical therapist (PT).

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Providers must submit the recipient's width and height for specialty walkers (E0140). Individuals approved for these walkers must be fitted and measured by the DME Company providing the service. Providers must submit invoice pricing and Medicaid will reimburse at provider's invoice price plus 20%.

E0148 Heavy Duty Walkers without wheels rigid or folding, any type each

E0149 Heavy Duty Walkers wheeled, rigid or folding, any type, each

Effective for dates of service on or after **July 1, 2014**, Alabama Medicaid will no longer require a PA for procedure code(s) E0148 and E0149. All appropriate documentation must be kept in the recipient's file and will be monitored by Alabama Medicaid.

E0168 Extra Wide Heavy Duty Stationary Commode Chair

Medicaid will approve E0148 and E0149 to accommodate weight capacities greater than 250 pounds and E0168 for weight capacities greater than 300 pounds.

Prior Authorization

The extra wide and/or heavy duty commode chairs and the stationary or mobile with or without arms will require PA. (See Section 14.3.1 Authorization for Durable Medical Equipment.)

Documentation

Providers must submit recipient's weight for the commode chairs, and weight, width and height for the walkers. A physician's prescription or order and medical documentation must be submitted justifying the need for the equipment.

14.2.6 Respiratory Suction Pumps

E0600 Suction Pump, Home Model, Portable

A portable or stationary home model respiratory suction pump is an electric aspirator designed for oropharyngeal and tracheal suction.

Prior Authorization

This procedure code requires PA. (See Section 14.3.1 Authorization for Durable Medical Equipment.)

Documentation

The suction pump must be prescribed as medically necessary in order to qualify for Medicaid reimbursement. 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 or mouth
- Dysfunction of the swallowing muscles
- Tracheostomy
- Unconsciousness or obtunded state

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The suction device must be appropriate for home use without technical or professional supervision. Individuals using the suction apparatus must be sufficiently trained to adequately, appropriately, and safely use the device.

This equipment may be purchased for any qualified Medicaid recipient who meets the above criteria. The information submitted must include documentation that the recipient meets the above medical criteria.

14.2.7 Insulin Devices and Supplies

E0607 Home Blood Glucose Monitor

E0607 Home blood glucose monitors, monitor replacement batteries, calibrator solution or chips, and spring powered lancet devices must be prescribed as medically necessary by the primary physician.

Prior Authorization

E0607 does not require PA.

Documentation

To be considered for coverage, Medicaid beneficiaries must be diagnosed as having either Type 1, Type 2, gestational diabetes, or receiving Total Parenteral Nutrition. Alabama Medicaid will reimburse covered diabetic supplies for Medicaid recipients that were diabetics prior to the pregnancy and for pregnancy related-diabetes. Reimbursement for these diabetic supplies will promote health and safety of mother and baby.

E2100 Home Blood Glucose Monitor with Integrated Voice Synthesizer

E2100 Blood glucose monitors with integrated voice synthesizers are covered when the patient meets the same requirements (listed above) as a regular glucometer in addition to the requirements below.

Prior Authorization

This procedure code requires PA. (See Section 14.3.1 Authorization for Durable Medical Equipment.)

Documentation

The patient's physician certifies that the patient has a visual impairment (20/200 or worse) severe enough to require use of this special monitoring system.

The patient's optometrist or ophthalmologist must certify the degree and type of visual impairment.

For procedure code **E2100** to be dispensed, a written statement that the recipient requesting a glucometer with voice synthesizer is capable of using the equipment in the home setting, and is not dependent upon a caregiver for blood glucose testing. (If the recipient is dependent upon a caregiver, the caregiver's need for a glucometer with a voice synthesizer must be justified.)

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Medical documentation justifying medical necessity must be in the recipient's file. Documentation in the recipient's file must also include certification that the recipient or their caregiver is receiving, or has received, diabetes education and training on the use of the glucose monitor, strips and lancets in the appropriately prescribed manner in the home.

The following supplies are also available for recipients who are eligible for the home blood glucose monitor:

Home Glucose Monitor Supplies

A4233 Replacement battery, Alkaline, other than J cell

A4234 Replacement battery, Alkaline, J cell

A4235 Replacement battery, Lithium

A4236 Replacement battery, Silver Oxide

A4256 Normal, low and high calibrator solution/chips

A4258 Spring-powered device for lancet, each

Supplies

Providers dispensing diabetic supplies must have the recipient's prescription or order on file from the primary care physician. A valid prescription or order will contain the frequency for daily blood sugar testing. Providers must ensure that diabetic supplies are dispensed based on the daily frequency of blood sugar testing indicated on the recipient's prescription or order.

It is the provider's responsibility to ensure that the recipient does not have an excessive supply of strips or lancets. If it is determined through provider audits that Medicaid has reimbursed the provider for excessive amounts of strips or lancets, the amount paid for the excessive supply will be recouped.

If recipients require additional strips or lancets above the Medicaid established limits, providers must submit a request to the Medical and Quality Review Unit at Medicaid for review and approval. The request must include the following:

1. Prescription or order,
2. number of times the recipient is testing per day,
3. documentation informing if recipient is insulin or non-insulin dependent,
4. two A1C or blood sugar test readings, and
5. for non-insulin dependent Type II diabetes, peer reviewed literature justifying the need for additional supplies.

If approval is granted, the Medical and Quality Review Unit will notify the DME Unit. Providers will also be notified of the approval and for these additional supplies, instructed to submit a clean CMS 1500 claim form with a short memo to Alabama Medicaid's DME Unit. The memo (with copy of approval notification attached) should state that the recipient has been approved for additional units and request Medicaid to override the maximum unit requirement and force payment of the claim.

A4250 - Urine test or reagent strips or tablets (100 tablets or strips), will be limited to one box of 100 count every month.

Non-Insulin Dependent Recipients

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Claims for **non-insulin** dependent recipients **must** be filed with the procedure code **WITHOUT using a modifier**.

A4253 – Blood glucose test or reagent strips for home blood glucose monitor, per box of 50, will be limited to **two** boxes every three months (providers may bill these strips two boxes in a one month period).

A4259 – Lancets, per box of 100, will be limited to **one** box every three months.

Insulin Dependent Recipients

Claims for **insulin** dependent recipients **must** be filed with the procedure code and **WITH MODIFIER U6.**

A4253 (U6) - Blood glucose test or reagent strips for home blood glucose monitor, per box of 50 will be limited to **three** boxes per month for insulin dependent recipients age **21 and above.**

A4253 (U6) - Blood glucose test or reagent strips for home blood glucose monitor, per box of 50 will be limited to **four** boxes every month for insulin dependent recipients age **0 – 20.**

A4259 (U6) - Lancets, per box of 100 will be limited to **two** boxes per month for insulin dependent diabetics regardless of age.

Recipients with Gestational Diabetes

Effective March 1, 2012, DME diabetic testing supply claims billed for recipients with Gestational Diabetes must contain a diagnosis code in the range of 64880 through 64884 for ICD-9, O24410 through O24439 and O99810 through O99815 for ICD-10.

A4259 – Lancets, per box of 100, will be limited to **two** boxes per calendar month

A4253 – Blood glucose test or regent strips for home blood glucose monitor, per box of 50, will be limited to **four** boxes per calendar month.

These claims will be processed electronically by Medicaid's fiscal agent. All documentation must be kept in the recipient's file and will be monitored by Alabama Medicaid on a quarterly basis.

NOTE:
Recipients who were diagnosed with diabetes prior to the pregnancy are eligible to receive diabetic equipment/supplies.

E0784 External Ambulatory Infusion Pump and Supplies

An external ambulatory infusion pump is a small portable battery device worn on a belt around the waist and attached to a needle or catheter designed to deliver measured amounts of insulin through injection over a period of time.

Prior Authorization

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The external ambulatory infusion pump is approved by Medicaid for use in delivering continuous or intermittent insulin therapy on an outpatient basis when determined to be appropriate medically necessary treatment, and must be prior authorized.

E0784 External Ambulatory Infusion Pump will be a capped rental item for twelve months. At the end of the twelve month period the item is considered to be a purchased item for the recipient paid in full by Medicaid. Any maintenance or repair cost would be subject to an EPSDT screening and referral and a PA as addressed under current Medicaid policy.

A9274 External ambulatory insulin delivery system, disposable, each, includes all supplies and accessories is approved by Medicaid effective August 1, 2014, for use in delivering continuous or intermittent insulin therapy on an outpatient basis when determined to be appropriate medically necessary treatment.

To date, the Omnipod 5 “G6” insulin pump has not been approved by the PDAC (Medicare Contractor for Pricing, Data Analysis and Coding) for billing under the existing external insulin pump and pod procedure codes, E0784 and A9274. Therefore, effective February 1, 2023, Omnipod insulin pumps and refill pods without an approved procedure code should be billed under E1399 with an SC modifier. More information on how to bill the Omnipod can be found below:

- As with other insulin pumps, the Omnipod will require a prior authorization (PA) and the current criteria for external insulin pumps/pods will be followed.
- The PA request should include the initial kit and refill pods.
- Providers must submit an invoice with each PA request and append the SC modifier on the PA request.
- If the invoice or modifier is not submitted with the PA, the PA will be denied.
- Providers will be reimbursed invoice cost + 20%.
- Requests for the other models, with an applicable procedure code, will continue to be billed and submitted under E0784 or A9274, respectively, and reimbursed per the amount listed on the fee schedule.

Approved Diagnoses

Approval will be given for only the following type 1 diabetes mellitus diagnosis codes, if the below linked criteria are met:

Diagnosis	Version	Diagnosis	Version	Diagnosis	Version	Diagnosis	Version
250.51	9	E10.36	10	E11.339	10	E13.29	10
250.53	9	E10.39	10	E11.341	10	E13.311	10
250.61	9	E10.40	10	E11.349	10	E13.319	10
250.63	9	E10.41	10	E11.351	10	E13.321	10
250.71	9	E10.42	10	E11.359	10	E13.329	10
250.73	9	E10.43	10	E11.36	10	E13.331	10
250.81	9	E10.44	10	E11.39	10	E13.339	10
250.83	9	E10.49	10	E11.40	10	E13.341	10
250.91	9	E10.51	10	E11.41	10	E13.349	10

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Diagnosis	Version	Diagnosis	Version	Diagnosis	Version	Diagnosis	Version
250.93	9	E10.52	10	E11.42	10	E13.351	10
250.01	9	E10.59	10	E11.43	10	E13.359	10
250.03	9	E10.610	10	E11.44	10	E13.36	10
250.11	9	E10.618	10	E11.49	10	E13.39	10
250.13	9	E10.620	10	E11.51	10	E13.40	10
250.21	9	E10.621	10	E11.52	10	E13.41	10
250.23	9	E10.622	10	E11.59	10	E13.42	10
250.31	9	E10.628	10	E11.610	10	E13.43	10
250.33	9	E10.630	10	E11.618	10	E13.44	10
250.41	9	E10.638	10	E11.620	10	E13.49	10
250.43	9	E10.641	10	E11.621	10	E13.51	10
E10.10	10	E10.649	10	E11.622	10	E13.52	10
E10.11	10	E10.65	10	E11.628	10	E13.59	10
E10.21	10	E10.69	10	E11.630	10	E13.610	10
E10.22	10	E10.8	10	E11.638	10	E13.618	10
E10.29	10	E10.9	10	E11.641	10	E13.620	10
E10.311	10	E11.00	10	E11.649	10	E13.621	10
E10.319	10	E11.01	10	E11.65	10	E13.622	10
E10.321	10	E11.21	10	E11.69	10	E13.628	10
E10.329	10	E11.22	10	E11.8	10	E13.630	10
E10.331	10	E11.29	10	E13.00	10	E13.638	10
E10.339	10	E11.311	10	E13.01	10	E13.641	10
E10.341	10	E11.319	10	E13.10	10	E13.649	10
E10.349	10	E11.321	10	E13.11	10	E13.65	10
E10.351	10	E11.329	10	E13.21	10	E13.69	10
E10.359	10	E11.331	10	E13.22	10	E13.8	10

External Ambulatory Insulin Infusion Pump Criteria Checklist

The criteria checklist must accompany the PA form. The checklist is located on the Alabama Medicaid website at the link below.

http://medicaid.alabama.gov/content/4.0_Programs/4.3_Pharmacy-DME/4.3.12_DME.aspx

The prescribing practitioner's signature is required to certify the patient meets criteria, treatment is supervised, and supporting documentation is attached to the request.

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Supplies Procedure Codes

E0784, A4232, A4230, A9274

Maximum yearly limits apply to each of the procedure codes indicated above. Requests for replacement of E0784 will be limited to once every **five** years based on a review of submitted documentation requested.

Alabama Medicaid will reimburse for supplies in quantities prescribed as medically necessary by the provider.

A4244, A4245, A4246, A4247, A4450, A4452, A4455, A4927, A4930, A6216, A6230, A6250, A6257, A6258, A6259, A6266, A6403, A6404, J1642

A4230 - Infusion set for external insulin pump, non-needle cannula type, will be limited to 30 units per two calendar months per recipient

A4230 (U6) - Infusion set for external insulin pump, non-needle cannula type will be limited to 70***** units per two calendar months per recipient. (Payment for this quantity will also require use of the appropriate diagnosis code listed in the table above **and** U6 modifier.)

A4232 - Syringe with needle for external insulin pump, sterile, 3cc will be limited to 30 units per two calendar months per recipient

A4232 (U6) - Syringe with needle for external insulin pump, sterile, 3cc will be limited to 70***** units per two calendar months per recipient. (Payment for this quantity will also require use of the appropriate diagnosis listed in the table above **and** U6 modifier.)

A9274 – External ambulatory insulin delivery system, disposable, each, includes all supplies and accessories.

*****The maximum number of units with or without a modifier is 70. Example: If 30 units are billed without U6 modifier, then 40 is maximum number of units billable with the U6 modifier during any two calendar months.

NOTE:

Procedure codes A4362 and A5121 may not be billed on the same date of service as A4414 or A4415. Procedure code A5063 may not be billed on the same date of service as A5052.

Continuous Glucose Monitor (CGM)

The use of the CGM device, for children 20 years old and younger with an EPSDT screening and for all ages who are pregnant, is considered medically appropriate if all of the following criteria are met in addition to the documentation requirements.

1. Patient is diagnosed with Type 1 diabetes mellitus; or pregnant female (Type 1 or 2); and
2. Patient is insulin-treated with multiple (three or more) daily injections of insulin or a Medicare-covered continuous subcutaneous insulin infusion (CSII) pump; and
3. Patient's insulin treatment regimen requires frequent adjustment by the patient and/or caregiver on the basis of BGM or CGM testing results; and

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4. Within six (6) months prior to ordering the CGM, the treating practitioner has an in-person visit with the patient to evaluate their diabetes control (to include HbA1c) and determine that criteria (1-4) above are met; and
5. Every six (6) months following the initial prescription of the CGM, the treating practitioner has an in-person visit with the beneficiary to assess adherence to their CGM regimen and diabetes treatment plan.

Replacement or upgrade of existing, properly functioning equipment, even if warranty has expired, is not considered medically necessary. The glucose sensor and transmitter components of a continuous glucose monitor used with a combined continuous subcutaneous insulin infusion and blood glucose monitoring devices may be considered medically necessary when all the above criteria met. Other uses of continuous monitoring of glucose levels in interstitial fluid as a technique of diabetic monitoring are considered not medically necessary and investigational. Coverage for non-medical items, even when the items may be used to serve a medical purpose, such as smart devices (smart phones, tablets, personal computers, etc.) are non-covered. This includes smart devices used in conjunction with Continuous Glucose Monitors.

Supplies Procedure Codes

For NEW prior authorization requests submitted on or after November 1, 2023, providers must bill and submit on the prior authorization CGM procedure codes A4239 and E2103 for non-adjunctive CGM models. Existing prior authorizations approved for A9276, A9277, and A9278 prior to November 1, 2023, will remain active and providers will be allowed to bill remaining units on existing prior authorizations through October 31, 2024. Providers must bill the SC modifier for the Dexcom brand CGM and bill the U6 modifier for the Freestyle brand CGM on claims with dates of service prior to November 1, 2023. Procedure codes A9276, A9277, and A9278 will be non-covered on November 1, 2024.

Medicaid Reimbursement for CGM:

Supplies provided for non-adjunctive, non-implanted CGM patients effective November 1, 2023 will include:

A4239 –CGM supplies and accessories (this includes sensors and transmitters)
1 month supply=1 billable unit by DME provider.

E2103-CGM monitor or receiver.

Quantities should not exceed a year supply. CGM receivers are limited to one every five years, require prior authorization and will be considered based upon the review of submitted documentation.

Supplies will be approved no longer than 1 year OR the expiration of the written order/prescription (whichever comes first).

Supply allowances for prior authorizations effective prior to November 1, 2023:

Dexcom CGM – SC Modifier
A9276-SC – Disposable Sensor, will be limited to 13 boxes per calendar year.
A9277-SC – External Transmitter, will be limited to 1 transmitter per 90 days and no more than 5 per calendar year

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A9278-SC – External Receiver, will be limited to one every five calendar years based on submitted documentation.
All supplies related to CGMs will only be available for purchase and will not be available for rental to purchase.

Freestyle CGM – U6 Modifer
A9276-U6 – Disposable Sensor, will be limited to 27 boxes per calendar year.
A9278-U6 – External Receiver, will be limited to one every five calendar years based on submitted documentation.

All supplies related to CGMs will only be available for purchase and will not be available for rental to purchase.

The procedure codes A9276, A9277, and A9278 will be covered up to one year to allow providers to bill remaining units on existing prior authorizations. Reimbursement for the procedure codes A9276, A9277, and A9278 will be made based on the fee listed on the max fee panel. The appropriate modifier must be entered on each line item of the prior authorization for each procedure code. Providers must bill the appropriate modifier to be reimbursed correctly for the brand CGM that is being dispensed.

Reimbursement for A4239 and E2103 will be established via manual pricing based on the provider's invoice cost + 20%.

Alabama Medicaid does not prefer one brand over the other. Prior authorizations are approved for one year.

Limitations:

The supplies are covered up to the maximum, allowed units for the specified timeframes (see supplies).

CGM devices are limited to one every five years, require prior authorization and will be considered based upon the review of submitted documentation. If the replacement is needed prior to the 5-year timeframe due to disaster or damage that is not the result of misuse, neglect or malicious acts by users; requests for consideration of payment for replacement equipment must be submitted to the prior authorization contractor with a police report, fire report or other appropriate documentation.

Recertification/Renewal:

For patients who have received CGM equipment and supplies through Alabama Medicaid and are in need of a Prior Authorization Renewal, an updated prescription and an attestation from the patient's prescribing provider, stating their recommendation for continued CGM therapy, is required. A request for replacement of the External Receiver will be considered for approval every five years upon review of submitted medical documentation. If a replacement request is submitted within less than five years and the replacement is due to a natural disaster and not the result of misuse, neglect or malicious acts by the user, the request may be considered for approval and payment.

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14.2.8 Hospital Bed

A physician must prescribe a hospital bed as medically necessary in order for a recipient to qualify for a hospital bed.

If a hospital bed is medically necessary and is needed for six months or less, the equipment will be rented. This policy is applicable for all Medicaid recipients. If the equipment continues to be medically necessary and is needed longer than six months another PA request and prescription or order must be submitted documenting the need. If approval is granted a capped rental will be established and previous rental payments will be applied towards the total purchase price of the equipment. Reimbursement will not exceed the total purchase price.

Prior Authorization

These procedure codes require PA. (See Section 14.3.1 Authorization for Durable Medical Equipment.)

Medicaid will use the established PA criteria for these hospital beds, but will add the weight requirement. DME providers will ensure that an accurate weight measurement is included with these requests.

Documentation

The recipient must meet one of the following conditions:

1. Recipient positioning of the body is not feasible on an ordinary bed, or
2. recipient has medical conditions that require head of bed elevation, or
3. recipient requires medical equipment which can only be attached to the hospital bed.

At least one of the criteria listed above must be met as well as any of the following for coverage of variable height hospital bed:

1. Recipient has medical condition or injuries to lower extremities and the variable height feature allows recipient to ambulate by placing feet on the floor while sitting on edge of bed.
2. Recipient's medical condition is such that they are unable to transfer from bed to wheelchair without assistance**.**
3. Severely debilitating diseases and conditions require the need of the variable height bed to allow recipient to ambulate or transfer.

Heavy Duty

This equipment may be purchased for any qualified Medicaid recipient who meets the above criteria.

E0303 Medicaid covers hospital beds (E0303) heavy duty, extra wide, with any type side rails, with mattress to accommodate weight capacities greater than 350 pounds, but less than 600 pounds.

E0304 Medicaid covers hospital beds (E0304) extra heavy duty, extra wide, with any type side rails, with mattress to accommodate weight capacities greater than 600 pounds. Medicaid will reimburse providers the established CURES Act rate for E0304.

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E1399 Replacement mattresses for the heavy duty, extra wide bed or the extra heavy duty bed can be obtained using procedure code E1399.

14.2.9 Hospital Bed Accessories

Hospital bed accessories must be prescribed as medically necessary, require PA (in most cases) and medical documentation must be submitted justifying the need.

Prior Authorization

Most accessory codes require PA.

E0275, **E0276,** and **E0621** do not require PA.

NOTE:
For benefit limits refer to the DME Fee Schedule.

Mattress Replacement

E0271: Mattress, innerspring

E0272: Mattress, foam rubber

To qualify for Medicaid reimbursement of a mattress replacement, a physician must prescribe the equipment as medically necessary. These procedure codes require PA. (See Section 14.3.1 Authorization for Durable Medical Equipment.)

Documentation

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.

Bed Side Rails

E0305: Bedside rails, half-length

E0310: Bedside rails, full length

A physician must prescribe bedside rails as medically necessary in order for a recipient to qualify for Medicaid reimbursement. These procedure codes require PA. (See Section 14.3.1 Authorization for Durable Medical Equipment.)

Documentation

The recipient must be bed confined and have one or more of the following conditions:

- Disorientation
- Positioning problem
- Vertigo
- Seizure disorder

Recipient Hydraulic Lift

E0630: Recipient Hydraulic Lift with Seat or Sling

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E0635: Electric Patient Lifts with Seat or Sling

Recipient hydraulic lifts will be considered for Medicaid payment when prescribed as medically necessary by a physician. These procedure codes require PA. (See Section 14.3.1 Authorization for Durable Medical Equipment.)

Documentation

An eligible recipient must meet the following medical criteria:

- Documentation must indicate the recipient has, or is highly susceptible to decubitus ulcers, or
- The recipient must be essentially bed confined and would require the assistance of more than one person to transfer from bed to chair or wheelchair or commode without a lift.

Medicaid covers electric patient lifts with seat or sling (E0635) to accommodate weight capacities greater than 450 pounds.

Prior Authorization

Medicaid will use the established PA criteria for these electric patient lifts but will add the weight and width requirements. Individuals approved for these electric lifts must be fitted and measured by the Durable Medical Equipment Company providing these services.

Medicaid will reimburse provider at invoice cost plus 20% for these patient electric lifts (E0635).

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

E0911: Medicaid covers Trapeze Bar (E0911), heavy duty for patient weight capacity greater than 250 pounds, Attached to Bed with Grab Bar.

E0912: Medicaid covers Trapeze Bar (E0912), heavy duty, for patient weight capacity greater than 250 pounds, Freestanding, complete with Grab Bar.

To qualify for Medicaid reimbursement of a trapeze bar, the physician must prescribe the equipment as medically necessary for the recipient. This procedure code requires PA. (See Section 14.3.1 Authorization for Durable Medical Equipment.)

Documentation

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.

Prior Authorization

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Medicaid will use the established PA criteria for these trapeze bars, but will add the weight requirements. Individuals approved for these trapeze bars must weigh over 250 pounds. Medicaid will reimburse providers the established CURES Act rate for procedure code E0912.

NOTE:
For benefit limits refer to the DME Fee Schedule.

14.2.10 Pediatric Bed/Crib

E0300: Pediatric crib, hospital grade, fully enclosed; can have side rails that extend more than 24 inches above the mattress (includes sleep safe type beds)

E0316: Safety enclosure frame/canopy for use with hospital bed, any type
The purchase of a safety enclosure frame, canopy or bubble top may be a benefit when the protective crib top or bubble top is for safety use. It is not considered a benefit when it is used as a restraint or for the convenience of family or caregivers.

E0328: Hospital bed, pediatric manual, 360 degree side enclosures, top of headboard, footboard and side rails up to 24 inches above the spring, includes mattress *(Does not include sleep safe type beds)*

E0329: Hospital bed, pediatric electric or semi-electric, 360 degree side enclosures, top of headboard, footboard and side rails up to 24 inches above the spring, includes mattress *(Does not include sleep safe type beds)*

A pediatric hospital bed or pediatric crib is defined as fully enclosed with all of the following features:

- Allows adjustment for the head and foot of the bed (manual or semi-electric)
- Headboard
- Footboard
- Mattress
- Side rails of any type (A side rail is defined as a hinged or removable rail, board or panel)
- A bed with side rails that extends 24 inches or less above the mattress is considered a pediatric hospital bed (E0328 or E0329)
- A bed with side rails that extends more than 24 inches above the mattress is considered a pediatric crib (E0300)

Pediatric hospital beds and pediatric cribs that do not have all of these features will not be considered for PA and will not be covered through Alabama Medicaid's DME Program.

E1399: Enclosed bed manufactured as a unit (does not include sleep safe bed types)

An enclosed bed is considered medically necessary when the recipient is cognitively impaired and mobile if his or her unrestricted mobility has resulted in documented injuries sustained as a result of wandering unsupervised. Even then, it must be shown that other, less costly methods have been attempted and have failed to effectively treat the problem. Generally, such confinement is not medically necessary nor the least costly

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way of managing seizures or behaviors such as head banging, rocking, etc. Issues of sensory deprivation and the potential for overuse must be addressed in this process.

Providers must submit documentation to support that the bed or crib system has been approved by the Food and Drug Administration (FDA). ***Enclosed bed systems that are not FDA approved are not covered by Alabama Medicaid.***

Documentation

Medicaid coverage is available for pediatric beds provided the beds are medically necessary and the criteria listed below are met:

1. Diagnosis of one of the following:
    - Brain Injury
    - Moderate to severe cerebral palsy
    - Seizure disorder with daily seizure activity
    - Developmental disability
    - Severe behavioral disorder
    - Documentation of the specific risk from unrestricted mobility including
        - Tonic-clonic type seizures
        - Uncontrolled perpetual movement related to diagnosis
        - Self-injurious behavior
2. Providers must submit documentation to support that the bed or crib system accommodates child's weight &/or height, and;
3. Less costly alternatives have been tried and rejected. Physician and guardians must attest to the alternative use trials. If no alternative therapies attempted, documentation must explain why. Prescribing physician will be required to submit attestation document.

    Documentation of alternative therapies used shall include the following information:

    - Date(s) used
    - Duration of Use
    - Name of Equipment used
    - Results of use
        - Number of injuries
        - Type of injuries
4. Written monitoring plan approved by the ordering and all treating practitioners which includes, at a minimum, the following information:
    - Time frame or situations for when the bed will be used
    - Methods for monitoring the recipient at specified time intervals
    - Strategies for meeting all of recipient's needs while using the enclosed bed (including eating, hydration, skin care, toileting, and general safety)

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- Identification, by relationship, of all caregivers providing care to the recipient
- An explanation of how any medical conditions (e.g., seizures) will be managed while the recipient is in the enclosed bed

Medicaid coverage of pediatric beds

If the pediatric bed is medically necessary and is needed for six months or less, the equipment will be rented. If the equipment continues to be medically necessary and is needed longer than six months a capped rental is established, previous rental payments will be applied towards the total purchase price of the equipment. Reimbursement will not exceed the total purchase price (fee schedule) of the equipment. *The PA will govern this process.* E0328 and E0329 will be reimbursed invoice + 20%.

14.2.11 Power Reducing Support Surfaces

Prior Authorization

Group 1 and Group 2 power reducing support surfaces require PA.

Group 1

Group 1 pressure reducing support surfaces are covered for the entire Medicaid population.

Group 1 pressure reducing support surfaces include:

- **E0181**: Powered Pressure Reducing Mattress Overlay/Pad, Alternating With Pump Includes Heavy Duty,
- **E0185**: Gel/Gel-Like Pressure Pad For Mattress,
- **E0182**: Pump For Alternating Pressure Pad, Replacement Only, and
- **A4640**: Replacement Pad for Use with Medically Necessary Alternating Pressure Pad Owned by Patient. (A4640 will be considered for Medicaid payment when prescribed as medically necessary by a physician.)

The gel or gel like pad for mattress (E0185), the pump for alternating pressure pad, replacement only (E0182) and the replacement pad for alternating pressure pad owned by the patient (A4640) are purchased items because they are not considered reusable.

Documentation

Medical documentation must be submitted with the PA request justifying the need.

Group 2

Group 2 pressure reducing support surfaces include **E0277**: Powered Pressure-Reducing Air Mattress. **Procedure code E0277 is only covered for children up to the age of 21 through the EPSDT Program.**

Initial approval of the powered pressure-reducing air mattress (E0277) will consist of up to 90 days. If the primary physician documents that the equipment continues to be medically necessary longer than six months, a ten month capped rental to purchase is established, and previous rental payments will be applied towards the total purchase price of the equipment. Rental payments include delivery, in service for caregiver,

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maintenance, repair and supplies if applicable. Medicaid's reimbursement will not exceed the total purchase price of the equipment.

Continued use of the Group 2 support surface is considered medically necessary until the ulcer is healed or, if healing does not continue, there is documentation in the medical record to show that the use of the Group 2 support surface is medically necessary for wound management.

Documentation

Medical documentation must be submitted with the PA request justifying the need.

Effective October 1, 2013, replacement pad for alternating pressure pad (A4640), powered pressure reducing mattress overlay pad/alternating with pump, heavy duty (E0181) and gel mattress overlay (E0185) will only require an initial PA approval. **After the initial approval, these items will be considered purchased and owned by the patient.**

14.2.12 E0570 Nebulizer

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. An authorized practitioner must prescribe it as medically necessary.

This equipment may be purchased for any qualified Medicaid recipient based on the criteria listed below.

Documentation

Supporting documentation must be retained in supplier's recipient file. Medical information intended to demonstrate compliance with coverage criteria may be included on the prescription or order but must be supported by information contained in the medical record. Supporting documentation, in addition to a prescription or order, may include but is not limited to the physician's office records, records from hospitals, nursing facilities, home health agencies, other healthcare professionals, etc.

Age Group	*Purchase or Rental Requirements*
Children 0-18	**Purchases** require documentation of one episode of severe respiratory distress associated with one of the following diagnoses: • Asthma • Reactive Airway Disease • Cystic Fibrosis • Bronchiectasis • Bronchospasm • HIV, Pneumocystosis, or complications of organ transplants or; • First time episodes associated with one of the above diagnoses.

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Age Group	*Purchase or Rental Requirements*
Recipients 19 years of age and above	**Purchases** require medical records documentation of one of the following diagnoses: • Asthma • Bronchiectasis • Cystic Fibrosis • Chronic Obstructive Pulmonary Disease or Emphysema • HIV, Pneumocystosis, or complications of organ transplants • Acute complications of pneumonia • 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).
Children and recipients 19 years of age and above	**Purchases** may be approved to deliver medications that can be administered only by aerosol (i.e. Pulmozyme for cystic fibrosis) and administered as an alternative to intravenous administration of those drugs (for example, nebulized tobramycin, colistin, or gentamicin).

14.2.13 Iron Chelation Therapy Equipment

Prior Authorization

This procedure code requires PA. (See Section 14.3.1 Authorization for Durable Medical Equipment.) This includes the Auto-Syringe Infusion Pump for Iron Chelation Therapy **(E0779),** Supplies for the infusion pump **(A4222)** and the Auto-Infusion Pump Repair for Iron Chelation Therapy (**E1399** & **K0739**).

Documentation

Iron Chelation Therapy equipment will be considered for Medicaid payment when prescribed as medically necessary by a physician for an eligible recipient who has been diagnosed as having Sickle Cell Disease.

Iron Chelation Therapy equipment will be purchased for any qualified Medicaid recipient who meets the above criteria, supported by documentation.

14.2.14 Augmentative Communication Devices

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 or 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 and enhancement.

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E2500 Speech generating device digitized speech using pre-recorded messages, less than or equal to eight minutes recording time.

E2502 Speech generating device, digitized speech using pre-recorded messages greater than 8 minutes, but less than or equal to 20 minutes recording time.

E2504 Speech generating device, digitized speech using pre-recorded messages greater than 20 minutes, but less than or equal to 40 minutes recording time.

E2506 Speech generating device, digitized speech using pre-recorded messages greater than 40 minutes recording time.

E2508 Speech generating device, synthesized speech requiring message formulation by spelling and access by physical contact with the device.

E2510 Speech generating device, synthesized speech permitting multiple methods of message formulation and access by physical contact with the device.

E2511 Speech generating software program, for personal computer or personal digital assistant.

E2512 Accessory for speech generating device**,** mounting system.

E2599 Accessory for speech generating device not otherwise classified.

V5336 Repair modification of augmentative communication system or device (excludes adaptive hearing aid).

Scope of services includes the following elements:

- Screening and evaluation
- ACD, subject to limitations
- Training on use of equipment

These are inclusive in the allowable charge and may not be billed separately.

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 referring provider. • Medical condition which impairs ability to communicate • Evaluation required by qualified, experienced professional • Prescription or order to be obtained after the evaluation and based on documentation contained in evaluation.
Adults, age 21+	• Referral must be within one year of application for ACD • Medical condition which impairs ability to communicate Evaluation by required qualified experienced professionals • Prescription or order to be obtained after the evaluation and based on documentation provided in the evaluation.

Evaluation Criteria

Qualified interdisciplinary professionals must evaluate the candidate. Qualified interdisciplinary professionals include:

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A. Interdisciplinary professionals include a speech-language pathologist and a physician.

1. Qualifications for a speech-language pathologist include:

- Master's degree from an accredited institution;
- Certificate of Clinical Competence in speech-language pathology from the American Speech, Language, and Hearing Association;
- Current Alabama license in speech-language pathology;
- No financial or other affiliation with a vendor, manufacturer or manufacturer's representative of ACDs; and
- Current continuing education in the area of Augmentative Communication.

2. A Physician must possess the following qualifications:

- Be a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the state in which the doctor performs such functions; and
- Have no financial or other affiliations with vendors, manufacturers, or other manufacturer's representative of ACDs.

B. Interdisciplinary professionals should also include, but may not be limited to, a physical therapist, social worker, and/or occupational therapist.

1. A physical therapist must possess the following qualifications:

- Bachelor's degree in Physical Therapy from accredited institution;
- Alabama license in Physical Therapy; and
- No financial or other affiliation with a vendor, manufacturer or manufacturer's representative of ACDs.

2. A social worker must possess the following qualifications:

- Bachelor's degree from accredited institution;
- Alabama license in Social Work; and
- No financial or other affiliation with a vendor, manufacturer or manufacturer's representative of ACDs.

3. An occupational therapist must possess the following qualifications:

- Bachelor's degree in Occupational Therapy from accredited institution;
- Alabama license in Occupational Therapy; and
- No financial or other affiliation with a vendor, manufacturer or manufacturer's representative of ACDs.

Prior Authorization

ACDs and services are available only through the Alabama Medicaid PA 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 or using an ACD. The request must include documentation regarding the medical evaluation by the physician and recipient information.

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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 and positioning
- Ability to access the device

The evaluation must be conducted within 90 days of the request for an ACD.

Providers should utilize the Augmentative Communication Device Evaluation Form on the website at this link, http://www.medicaid.alabama.gov/documents/9.0_Resources/9.4_Forms_Library/9.4.14_PA_Forms/9.4.14_PA_Form_480_ACD_Eval_Report_FILLABLE_3-29-11.pdf

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Medicaid requires the following recipient information with the PA request:

Topic	***Information required for the PA***
Identifying information	• Name • Medicaid recipient number • Date(s) of Assessment • Medical diagnosis (primary, secondary, tertiary) • Relevant medical history
Sensory status (As observed by physician)	• Vision • Hearing • Description of how vision, hearing, tactile and/or receptive communication impairments affect expressive communication (e.g., sensory integration, visual discrimination)
Postural, Mobility & Motor Status	• Motor status • Optimal positioning • Integration of mobility with ACD • Recipient's access methods (and options) for ACD
Development Status	• Information on the recipient's intellectual/cognitive/development status • Determination of learning style (e.g., behavior, activity level)
Family/Caregiver and Community Support Systems	A detailed description identifying caregivers and support, the extent of their participation in assisting the recipient with use of the ACD, and their understanding of the use and their expectations
Current Speech, Language and Expressive Communication Status	• Identification and description of the recipient's expressive or receptive (language comprehension) communication impairment diagnosis • Speech skills and prognosis • Communication behaviors and interaction skills (i.e. styles and patterns) • Description of current communication strategies, including use of an ACD, if any • Previous treatment of communication problems
Communication Needs Inventory	• Description of recipient's current and projected (for example, within 5 years) speech-language needs • Communication partners and tasks, including partner's communication abilities and limitations, if any • Communication environments and constraints which affect ACD selection and/or features
Summary of Recipient Limitations	Description of the communication limitations
ACD Assessment Components	Justification for and use to be made of each component and accessory requested
Identification of the ACDs Considered for Recipient-Must Include at Least Three (3)	• Identification of the significant characteristics and features of the ACDs considered for the recipient • Identification of the cost of the ACDs considered for the recipient (including all required components, accessories, peripherals, and supplies, as appropriate) • Identification of manufacturer • Justification stating why a device is the least costly, equally effective alternative form of treatment for recipient • Medical justification of device preference, if any
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

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Topic	*Information required for the PA*
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 evaluations by appropriate professionals.

Limits

ACDs including components and accessories will be modified or replaced only under the following circumstances:

- Medical Change: Upon the request of recipient if a significant medical change occurs in the recipient's condition that significantly alters the effectiveness of the device.
- Age of Equipment: ACDs outside the manufacturer's or other applicable warranty that do not operate to capacity will be repaired. At such time as repair is no longer cost effective, replacement of identical or comparable component or components will be made upon the request of the recipient. Full documentation of the history of the service, maintenance, and repair of the device must accompany such request.
- Technological Advances: No replacements or modifications will be approved based on technological advances unless the new technology would meet a significant medical need of the recipient which is currently unmet by present device.

All requests for replacement or modification as outlined above require a new evaluation and complete documentation.

Other Information

Topic	*Required for the PA*
Invoice	The PA request and the manufacturer's invoice must be forwarded to Medicaid's Fiscal Agent PA department.
Trial Period	No communication components will be approved unless the client has used the equipment and demonstrated an ability to use the equipment. PA 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. PAs for rental of ACD device E2510 may be approved for a four week trial period of usage by the recipient. The manufacturer must agree to this trial period. Medicaid will reimburse the manufacturer for the dollar amount authorized by Medicaid for the four (4) week trial period. This amount will be deducted from the total purchase price of the ACD device.

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Topic	*Required for the PA*
Repair	Repairs are covered only to the extent not covered by manufacturers' warranty. Repairs must be prior approved and billed using procedure code V5336. Battery replacement is not considered repair but does require PA using procedure code E2599.
Loss/Damage	Replacement of identical components due to loss or damage must be prior approved. These requests will be considered only if the loss or damage is not the result of misuse, neglect, or malicious acts by the users.
Component / Accessory Limits	No components or accessories will be approved that are not medically required. Examples of non-covered items include but are not limited to the following: • Printers • Modems • Service contracts • Office/business software • Software intended for academic purposes • Workstations • Any accessory that is not medically required.

The ACD device must be tailored to meet each individual recipient's needs. Therefore, a recipient may need to try more than one device until one is suitable to meet their needs is identified. The Medicaid Agency will allow rental of the device, on a week to week basis, for a maximum one month with a maximum rental cap amount. The amount paid for this rental will be deducted from the total purchase price of the ACD device. The procedure code for one month rental of this device is E2510 (RR).

14.2.15 Wheelchairs

To qualify for Medicaid reimbursement of a wheelchair, the authorized practitioner must prescribe the equipment as medically necessary for the recipient. These procedure codes require PA. (See Section 14.3.1 Authorization for Durable Medical Equipment.)

Documentation

The recipient must be essentially bed confined and must meet the following documented conditions:

- The recipient must be essentially chair confined or bed to chair confined.
- The wheelchair is expected to increase mobility and independence.

Limitation and Exclusions

- Within the seven year period, Medicaid will not repair or replace equipment that is lost, destroyed, or damaged as a result of misuse, neglect, loss or wrongful disposition of equipment by the recipient, the recipient's caregiver(s), or the provider. At a minimum, example of equipment misuses, neglect, loss or wrongful disposition by the recipient, recipient's caregiver, or the provider include, but are not limited to the following:
    a. Loss of wheel chair or parts.
    b. Selling or loaning wheelchair or parts.
    c. Damage due to weather.
    d. Failure to store the wheelchair in a secure and covered area when not in use.

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e. Use on public roadways where the speed limit is greater than 25 miles per hour.

f. Loss, destruction or damage caused by the malicious, intentional or negligent acts.

Patient Education

- Provider is responsible for patient education and documentation of appropriate usage of wheelchair. Patient education shall include, but not be limited to, proper storage, usage on or off public roadways, battery life, cleaning, warranty, etc.
- Documentation of patient education and understanding by both the servicing provider and the recipient or caregiver shall be kept in the patient file for the life of the wheelchair.

Effective August 1, 2017, Medicaid's annual limit for manual or power/motorized wheelchairs is one every five years for children ages 0-20, and one every seven years for adults ages 21 and older.

Effective July 1, 2017, Medicaid's **Wheelchair Modification/Repair Form 386** will be **mandatory** for prior authorizations submitted July 1. 2017 and after for all requested wheelchair modification or repairs requiring a PA. This form must be completed signed and dated by an Alabama-licensed Physical Therapist (PT) or Occupational Therapist (OT), **if** a PT/OT assessment was required for the modification to address changing/growing the seating; changing drive controls; adding a power function or power assist, etc. The PT/OT should have experience and training in mobility evaluations and must be employed by a Medicaid-enrolled hospital outpatient department. The form may read, "See Letter of medical necessity," which may be attached to the form. Otherwise, justification may be provided by the repair technician or provider ATP/SMS on the form. The form should be dated and have the printed name and signature of the provider. This form is located on Medicaid's website at www.medicaid.alabama.gov.

Effective October 1, 2011, Medicaid's Wheelchair/Seating Evaluation Form 384 must be completed with all PA requests for **Manual Wheelchairs** with additional accessories for adults. The evaluation must be performed by an Alabama licensed Physical Therapist (PT) or Occupational Therapist (OT) who has experience and training in mobility evaluations and is employed by a Medicaid enrolled hospital outpatient department. This form must be completed by the PT or OT who performed the assessment. This form is located on Medicaid's website at www.medicaid.alabama.gov.

Standard Wheelchair

A standard wheelchair should be requested unless documentation supports the need for any variation from the standard wheelchair. An example of this variation is an obese recipient who requires the wide heavy-duty wheelchair (E1093). For a list of valid wheelchair procedure codes, refer Appendix P, Durable Medical Equipment (DME) Procedure Codes and Modifiers.

HCPCS E1050 through E1200 and K0005 will be used as appropriate for standard wheelchairs.

Heavy Duty Wheelchairs

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K0007 Medicaid reimburses DME providers for Extra Heavy Duty Wheelchairs. These wheelchairs accommodate weight capacities up to 600 lbs. Medicaid covers these wheelchairs as a purchase by using HCPCS code K0007.

K0009 Medicaid covers the 'Other manual wheelchair/base' (K0009) to accommodate weight capacity of 600 pounds or greater. Medicaid will reimburse for procedure code K0009 at provider's invoice price plus 20%.

Medicaid will require weight, width and depth specification for procedure codes K0007 and K0009.

K0108 The 'Wheelchair component or accessory not otherwise specified' for the wheelchair will be covered using procedure code K0108. The established PA criteria for these specified codes will be used.

NOTE:

The provider must ensure that the wheelchair is adequate enough to meet the recipient's need. For instance, providers should obtain measurements of obese recipients to ascertain body width for issuance of a properly fitted wheelchair.

This equipment may be purchased for any qualified Medicaid recipient who meets the above criteria. This equipment may also be rented for any eligible Medicaid recipient. The information submitted must include documentation that the recipient meets the above medical criteria.

Motorized/Power Wheelchairs

Medicaid covers motorized or power wheelchairs for the entire Medicaid population. To qualify for motorized or power wheelchairs an individual must meet full Medicaid financial eligibility and established medical criteria. All requests for motorized or power wheelchairs are subject to Medicaid PA provisions established by Medicaid. The patient must meet criteria applicable to manual wheelchairs pursuant to the Alabama Medicaid Agency Administrative Code Rule No. 560-X-13-.17. **HCPCS K0813 through K0816, K0820 through K0831, K0835 through K0843, K0848 through K0864, K0868 through K0871, K0877 through K0880, K0884 through K0886, K0890, K0891, and K0898 will be used as appropriate for related motorized wheelchairs.**

Providers must use an appropriate code for power or custom manual wheelchairs and accessories if one is available. If there is no appropriate code, then the provider can use K0108. All PA requests submitted using procedure code K0108 will be reviewed to ensure that there is not another code available.

Providers should submit K0108 for a "growth kit," after ensuring the manufacturer does not provide a growth kit free of charge. A statement that the provider verified the information about the growth kit should also be submitted.

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Documentation

The prescriber must provide documentation that a manual wheelchair cannot meet the individual's medical needs, and the patient requires the motorized or power wheelchair for six (6) months or longer.

Prior Authorization

The following is the process for obtaining prior approval of a motorized or power wheelchair and accessories:

- The prescriber must provide the patient with a prescription or order for the motorized or power wheelchair.
- The prescriber must provide medical documentation that describes the medical reason(s) why a motorized or power wheelchair is medically necessary. The medical documentation should also include diagnoses, assessment of medical needs, and a plan of care.
- The patient must choose a DME provider to supply the wheelchair.
- The DME provider should arrange to have the Alabama Medicaid Agency **Motorized/Power Wheelchair Assessment Form 384** completed by an Alabama licensed OT or PT who is employed by a Medicaid enrolled hospital outpatient department (unless otherwise approved by Alabama Medicaid). The OT or PT must perform the evaluation/assessment. (This form is located on Medicaid's website: www.medicaid.alabama.gov.) Form 384 is considered outdated by Medicaid when it is presented to the DME provider or Medicaid's Fiscal Agent past 90 days from the date the PT evaluation was completed. If Form 384 was received timely for the initial request but the PA is denied and Form 384 becomes outdated, the provider can submit an amendment in the form of a memo or letter with the reconsideration documents or the OT or PT can sign, date, and attest at the bottom of Form 384 that there have been no significant change(s). The amendment and/or signature should verify that there have been no significant change(s) to the recipient's condition since the completion of the evaluation and that the requested wheelchair and accessories are still appropriate to meet the recipient's mobility needs. **The PT's evaluation is paid separately and is not the responsibility of the DME provider.** Reimbursement is only available for physical therapists and occupational therapists employed by a Medicaid enrolled hospital through the hospital outpatient department. An OT or PT not employed by a Medicaid enrolled hospital may perform the wheelchair assessment without any reimbursement from Medicaid. The OT or PT performing the wheelchair assessment should not be employed with the DME Company or contracted by the DME Company requesting the physical therapy evaluation. If it is determined that the OT or PT is affiliated with the DME Company the OT or PT will be penalized and referred to the Alabama Medicaid Fraud Control Unit.
- This form must be completed (i.e. written or typed) by an Alabama licensed physical therapist or occupational therapist employed by an enrolled hospital through the hospital outpatient department. *(For clarification: The use of a scribe is highly discouraged unless needed in extenuating circumstances such as physical limitation by evaluating therapist. If scribe is used, attestation statement along with reason for use of scribe should be provided).*

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- If Form 384 was received timely for the initial request but the PA is denied and Form 384 becomes outdated, the OT or PT can submit an amendment in the form of a memo or letter with the reconsideration documents or the OT or PT can sign, date, and attest at the bottom of Form 384 that there have been no significant change(s). The amendment and/or signature should verify that there have been no significant change(s) to the recipient's condition since the completion of the evaluation and that the requested wheelchair and accessories are still appropriate to meet the recipient's mobility needs. **The PT's evaluation is paid separately and is not the responsibility of the DME provider.**
- Reimbursement is only available for physical therapists and occupational therapists employed by a Medicaid enrolled hospital through the hospital outpatient department. An OT or PT not employed by a Medicaid enrolled hospital may perform the wheelchair assessment without any reimbursement from Medicaid. The OT or PT performing the wheelchair assessment should not be employed with the DME Company or contracted by the DME Company requesting the physical therapy evaluation. If it is determined that the OT or PT is affiliated with the DME Company the OT or PT will be penalized and referred to the Alabama Medicaid Fraud Control Unit.
- The DME provider must submit the PA request electronically. Refer to Chapter 4, Obtaining Prior Authorization, about PA submissions and electronic upload of supporting documentation.
- PA requests for a power wheelchair must provide documentation that the recipient is able to independently use the requested item, either through a trial of the equipment (strongly recommended), or information to substantiate this ability. Information may be documented on the Motorized/Power Wheelchair Assessment Form (Form 384).
- Alabama Medicaid Agency or designated contractor may request additional information to support the appropriateness of this request. Additionally, a request for a trial may be required to determine if the recipient can independently operate the wheelchair.
- The DME provider must ensure that the PA request for the motorized or power wheelchair includes the product's model number, product name the name of the manufacturer. Providers must submit an itemized list of wheelchair, wheelchair accessory codes and pricing with the PA request.

Effective July 1, 2009, PA requests for wheelchairs received will no longer require providers to submit signed delivery tickets for wheelchairs to Medicaid before the PA request is placed in an approved status in the Alabama Medicaid Interchange PA System. ***However, a signed delivery ticket must be in the recipient's record for auditing purposes.*** If a recipient's record is audited and there is no signed delivery ticket showing proof of delivery of the wheelchair, Medicaid will recoup all monies paid for the wheelchair.

Criteria required for providing Group 2 Power Wheelchairs

Suppliers providing power wheelchairs and/or power operated vehicles to recipients must have at least one employee with certification from Rehabilitation Engineering and Assistive technology Society of North America (RESNA) registered with the National Registry of Rehab Technology Suppliers (NRRTS) or Assistive Technology Professional (ATP) certificate.

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As an alternate, a supplier shall be certified as a Certified Rehab Technology Supplier (ATS) from Rehabilitation Engineering and Assistive Technology Society of North American (RESNA). Only suppliers who are certified may participate. For information regarding certification through RESNA call (703) 524-6686 or www.RESNA.org.

(For Group 3 certification requirements, please see below.)

Group 3 Power Wheelchairs (No Power, Single Power and Multiple Power Options)

Group 3 Power Wheelchairs all require the following qualifications:

1. The beneficiary requires a power wheelchair for mobility and to perform mobility related activities of daily living (MRADL) in the home and/or community settings; and
2. The beneficiary's mobility limitation is due to a neurological condition, myopathy, congenital skeletal deformity, or similar medically, functionally limiting condition; and
3. The beneficiary has had a specialty evaluation that was performed by a licensed/certified medical professional, such as a Physical Therapist (PT), Occupational Therapist (OT), or physician who has specific training and experience in rehabilitation wheelchair evaluations that documents the medical necessity for the wheelchair and its special features. The PT, OT or physician may have no financial relationship with the supplier; and
4. The wheelchair is provided by a supplier that employs a RESNA-certified Assistive Technology Professional (ATP) who specializes in wheelchairs and who has direct, in-person involvement in the wheelchair selection for the beneficiary.

Requests for EPSDT-referred specialized wheelchair systems

Medicaid uses Medicare-based allowable amounts 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:
- Electronic ancillary products – 15% discount from MSRP
- Non-electronic ancillary products – 20% discount from MSRP

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Effective May 1, 2011, and thereafter, DME providers will no longer submit PA requests for custom wheelchairs and custom wheelchair accessories for children age 0-20 using procedure code E1220. DME providers will be required to use valid procedure codes, from the DME Fee Schedule, when submitting PA requests for custom wheelchairs and custom wheelchair accessories for children age 0-20, whenever possible. DME providers may use procedure code K0108 (wheelchair component or accessory, not otherwise specified), for wheelchair accessories that have no valid procedure code listed on the DME Fee Schedule.

Complex Rehabilitation Technology (CRT) Category

Effective October 1, 2012, Alabama Medicaid provides recognition for individually configured complex rehabilitation technology (CRT) products and services for complex needs patients under the age of 21. These HCPCS codes include complex rehabilitation power wheelchairs, highly configurable manual wheelchairs, adaptive seating and positioning systems, and other specialized equipment such as standing frames and gait trainers. Refer to Appendix P, Durable Medical Equipment (DME) Procedure Codes and Modifiers, for applicable CRT procedure codes.

Wheelchair Repairs

Suppliers providing motorized or power wheelchairs or subsequent repairs or replacement parts to recipients must have at least one employee with certification from Rehabilitation Engineering and assistive Technology Society of North America (RESNA) or registered with the National Registry of Rehab Technology Suppliers (NRRTS). The NRRTS or RESNA certified professional must have direct in person involvement in the wheelchair selection for the patient. RESNA certifications must be updated every two years. NRRTS certifications must be updated annually. If the NRRTS or-RESNA's certification is found not to be current, Alabama Medicaid's PA Contractor will deny the PA request for the wheelchair.

Prior Authorization

Repairs and replacement of parts for motorized or power wheelchairs will require PA by Medicaid. PA may be granted for repairs and replacement parts for motorized or power wheelchairs not previously paid for by Medicaid and those prior authorized through the EPSDT program. Wheelchair repairs and replacement parts for motorized or power wheelchairs may be covered using the appropriate HCPCS code listed in Section 14.5.3 under Wheelchair Accessories.

- Home, environmental and vehicle adaptions, equipment and modifications for wheelchair accessibility are not covered.

Reimbursement may be made for up to one month for a rental of a wheelchair using procedure code K0462 while patient owned wheelchair is being repaired. When submitting a PA request for loaner wheelchairs providers must submit the appropriate procedure code for the loaner wheelchair dispensed. Medicaid will then establish the monthly rental at 80% of Medicare's allowable price for the wheelchair code. If a loaner wheelchair is not needed for the entire month the wheelchair rental fee will be prorated on a daily basis. When submitting the claim to Medicaid's Fiscal Agent for payment, providers must bill using procedure code K0462 with the Medicaid established rate as it appears on the PA approval form.

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14.2.16 Wheelchair Low Pressure and Positioning Equalization Pad

E2603 Skin protection wheelchair seat cushion, width less than 22 in, any depth

E2604 Skin protection wheelchair seat cushion, width 22 in or greater, any depth

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.

Prior Authorization

The above listed procedure codes require PA. (See Section 14.3.1 Authorization for Durable Medical Equipment.)

Documentation

To qualify for Medicaid reimbursement or a Low Pressure and Positioning Equalization Pad for a wheelchair, the recipient must meet the following **documented** criteria:

- A licensed prescriber must prescribe the equipment as medically necessary.
- Recipient must have a decubitus ulcer or skin breakdown.
- Recipient must be essentially bed or 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.

K0108

Medicaid also reimburses DME providers for the ROHO Cushions for the Extra Heavy Duty Wheelchair. This wheelchair cushion is covered as a purchase through Medicaid using Medicare's procedure code K0108. This HCPCS code may be used to cover wheelchair cushions for obese individuals who could not use HCPCS codes E2603 and E2604.

NOTE:
Medicaid will use the established PA criteria for the Extra Heavy Duty Wheelchair and ROHO Cushion, but will add weight, width and depth specifications. Individuals approved for these items must be fitted and measured for wheelchair and cushion by the DME company providing these services.

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14.2.17 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. Beginning 11/1/2020 and continuing until a time determined by the Alabama Medicaid Agency, oxygen saturation measurements will not be required.

NOTE:

Include a copy of the Oxygen Certification Form (Form 360) with oxygen requests. Form 360 is used for initial certification, recertification, and changes in the oxygen prescription or order. This form must be filled out, signed and dated by the prescriber if it is being used as the prescription.-A DME supplier representative may sign and date the form if the DME provider is submitting both the prescription signed by the prescriber AND Form 360 to Medicaid's fiscal agent for prior authorization review.

Prior Authorization

Oxygen therapy is a covered service for the entire Medicaid population based on medical necessity and requires PA. (See section 14.3.1 Authorization for Durable Medical Equipment) The DME provider will be notified in writing of the assigned effective date and additional justification requirements, if applicable.

In order to receive a PA number, the Form 360 must be completed and submitted to Medicaid's fiscal agent. Oxygen therapy is based on the degree of desaturation or hypoxemia.

Documentation

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.

b. Recipients must meet the following criteria:

i. Adults with a current **ABG** with a **PO2 at or below 59 mmHg** or an **oxygen saturation at or below 89 percent**, taken at rest, breathing room air. If the prescriber certifies that an ABG procedure is unsafe for a patient, an oximetry for SaO2 may be performed instead. Pulse oximetry readings on adults will be considered only in unusual circumstances. Should pulse oximetry be performed, the prescribing physician must document why oximetry reading is necessary instead of arterial blood gas.

ii. An adult with an arterial PO2 at or below 55mmHg, or an oxygen saturation at or below 88%, for at least five minutes during sleep for a recipient who demonstrates an arterial PO2 above 59mm Hg or an O2 saturation at or above 90% while awake. The five minutes do not have be consecutive.

iii. A decrease in arterial PO2 more than 10mm Hg, or a decrease in O2 saturation more than five percent from the baseline saturation, for at least five minutes taken during sleep associated with symptoms (e.g., impairment of cognitive processes and nocturnal restlessness or insomnia, or signs

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(e.g. cor pulmonale, “P” pulmonale on EKG, documented pulmonary hypertension and erythrocytosis) reasonably attributed to hypoxemia.

iv. An arterial PO2 at or below 55mmHg or an O2 saturation at or below 88%, taken during activity for a recipient who demonstrates an O2 saturation at or above 90% during the day while at rest.

v. Recipients 20 years old or younger 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 or orders for oxygen therapy must include **all of the following**:

i. type of oxygen equipment

ii. oxygen flow rate or concentration level

iii. frequency and duration of use

iv. estimate of the period of need

v. circumstances under which oxygen is to be used

d. Medical necessity initial approval is for no more than twelve months. To renew approval, ABG or oximetry is required within six months prior to the end 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 timely before the end of the initial approval period, approval for a renewal will be granted beginning with the date of the qualifying ABG or oximetry reading.

e. Criteria for equipment reimbursement

i. Oxygen concentrators will be considered for users requiring one or more tanks per month of compressed gas (stationary unit). Prior approval requests will automatically be subjected to a review to determine if a concentrator will be most cost effective.

ii. Reimbursement will be made for portable O2 only in gaseous form. Medicaid will cover portable oxygen for limited uses such as physician visits or trips to the hospital. This **must** be stated as such on the medical necessity or prior approval request. Portable systems that are used on a standby basis only will not be approved. **Only one portable system (E0431) consisting of one tank and up to one refill (E0443) per month will be approved based on a review of submitted medical justification.** An example of justification for refills includes, but is not limited to, multiple weekly visits for radiation or chemotherapy.

iii. **E1392:** A portable oxygen concentrator may be approved if the reimbursement is more cost effective than a tank and multiple refills. The portable oxygen concentrator must accommodate the oxygen flow rate prescribed for the recipient and the time needed for portable oxygen, e.g. medical appointments.

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- If a recipient requires more than one refill (E0443), the provider must submit justification as to why the portable concentrator does not meet recipient's needs. If not documented, the recipient must be provided a portable concentrator. Medicaid will reimburse for only one stationary system.

iv. The DME supplier, and its employees, may not perform the ABG study or oximetry analysis used to determine medical necessity for recipients receiving nocturnal oxygen only. The provider cannot perform the oxygen saturation reading for recipients receiving oxygen 24 hours per day.

v. For recertification, the DME supplier may perform the oximetry analysis to determine continued medical necessity for recipients receiving nocturnal oxygen only. A printed download of the oximetry results must be submitted with a PA request. Handwritten results will not be accepted.

NOTE:

There are no restrictions related to oxygen flow rate and eligibility for oxygen coverage. The restriction is related **only** to the procedure codes covered.

Only one portable system consisting of one tank and up to four refills per month will be approved based on a review of submitted medical justification.

14.2.18 Pulse Oximeter

E0445 Pulse oximetry is a non-invasive method of determining blood oxygen saturation levels to assist with determining the amount of supplemental oxygen needed by the patient.

Pulse oximeters are a covered service for EPSDT eligible individuals who are already approved for supplemental home oxygen systems and whose blood saturation levels fluctuate, thus requiring continuous or intermittent monitoring to adjust oxygen delivery.

Prior Authorization

This procedure code requires PA. (See Section 14.3.1 Authorization for Durable Medical Equipment)

To receive a PA, submit an electronic request to include, but is not limited to, all of the following requirements:

- Required supporting documentation;
- Copy of EPSDT form or referral; and
- Copy of prior approval form for home oxygen (Form 360).

The use of home pulse oximetry, for pediatric patients, is considered medically appropriate if **one** of the following criteria in documentation requirements A is met in addition to **both** of the documentation requirements in B:

Documentation Requirements A:

1. Patient is ventilator dependent with supplemental oxygen required; or
2. Patient has a tracheostomy and is dependent on supplemental oxygen; or

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3. Patient requires supplemental oxygen per Alabama Medicaid criteria (see below) and has unstable saturations[1]; or
4. [1]Patient is on supplemental oxygen and weaning is in process; or
5. Patient is diagnosed with a serious respiratory diagnosis and requires short term[2] oximetry to rule out hypoxemia or to determine the need for supplemental oxygen.

Documentation Requirements B:

The following documentation is required:

1. **Pulse oximetry evaluations**. To qualify, from birth through three years must have a SaO2 equal to or less than 94%. Recipients age four and above must have a SaO2 equal to or less than 89%. Conditions under which lab results were obtained must be specified. When multiple pulse oximetry readings are obtained the qualifying desaturations must occur for five or more minutes (cumulative desaturation time) to qualify. Pulse oximetry evaluations are acceptable when ordered by the prescriber, and performed under his/her supervision, or when performed by a qualified provider or supplier of laboratory services. **A DME supplier is not a qualified provider of lab services.**
2. **Plan of Care.** A plan of care updated within 30 days of request must be submitted to include, at a minimum, plans for training the family or caregiver: The training plan shall provide specific instructions on appropriate responses for different scenarios, i.e., what to do when O2 Stats are below 89%.

   Initial approval will consist of up to 90 days only. For requests secondary to the need to determine the appropriateness of home oxygen liter flow rates, to rule out hypoxemia and/or to determine the need for supplemental oxygen, approval will be granted for up to 30 days only. Renewal may be requested for patients already approved for oxygen coverage by Medicaid. Documentation may also include written or printed results of pulse oximetry readings obtained within the last month with documentation of condition(s) present when readings were obtained. Renewal may be granted for up to a seven-month period for patients receiving oxygen coverage through Alabama Medicaid.

Qualifying Diagnoses:

- Lung disease, including but not limited to interstitial lung disease, cancer of the lung and cystic fibrosis bronchiectasis
- Hypoxia related symptoms/conditions, such as pulmonary hypertension
- Recurrent CHF secondary to cor pulmonale
- Erythrocytosis
- Sickle cell disease
- Severe Asthma

[1]Unstable saturations are documented desaturations which require adjustments in the supplemental oxygen flow rates to maintain saturation values. This should be documented to have occurred at least once in a 60 day period immediately preceding the request for certification or recertification.

[2]Short-term is defined as monitoring and evaluation for up to 30 days. “Spot oximetry” is not covered under this policy.

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- Hypoplastic heart disease
- Suspected sleep apnea or nocturnal hypoxia
- Other diagnoses with medical justification

Coverage Information

The Pulse Oximeter must be an electric desk top model with battery backup, alarm systems, memory and have the capacity to print downloaded oximeter readings. Downloads for each month of the most current certification period are required for all recertification requests. Recertification is required until the recipient no longer meets criteria or the device is removed from the home. If the pulse oximeter is no longer medically necessary (criteria no longer met), the oximeter will be returned to the supplier and may be rented to another client who meets criteria for pulse oximeter.

This device will be rented for up to three months during the initial certification period. If this device is needed beyond the initial certification period, the equipment will then become a rent to purchase item for an additional seven month period. The monthly payment will include delivery, in-service for the caregiver, maintenance, repair, supplies and 24-hour service calls. After the ten month rental period, the equipment is paid in full and no additional payment will be made by Alabama Medicaid. The pulse oximeter will be considered to be owned by the recipient.

Medicaid will pay for repair of the pulse oximeter after the initial 10 months only to the extent not covered by the manufacturer's warranty. Repairs must be prior authorized and the necessary documentation to substantiate the need for repairs must be submitted to Medicaid's fiscal agent who will forward this information to Medicaid's PA Unit. In addition, one reusable probe per recipient per year will be allowed after the initial 10 months capped rental period.

Limitations

Diagnoses not covered:

- Shortness of breath without evidence of hypoxemia
- Peripheral Vascular Disease
- Terminal illnesses not affecting the lungs, such as cancer not affecting the lungs or heart disease with any evidence of heart failure or pulmonary involvement.

Pulse oximeter requests for renewal will not be approved after the initial monitoring or evaluation period for those recipients not meeting criteria for oxygen coverage. Spot oximetry readings are a non-covered service under the DME program.

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14.2.19 Pulse Oximeter Supplies

Supplies for the Pulse Oximeter will only be paid for by Medicaid after completion of the ten month rental period.

A4606 - non disposable probe

A4606 – disposable probe

NOTE:
When requesting disposable probes medical documentation must be submitted justifying the need for disposable probes. The documentation must show why a disposable probe is medically necessary.

14.2.20 Volume Ventilator

E0465-(R)- Home ventilator, any type used with invasive interface, (e.g., tracheostomy tube)

E0466-(R)- Home ventilator, any type, used with non-invasive interface, (e.g., mask, chest shell)

Volume Ventilators are stationary or portable, with backup rate feature, and used with non-invasive or invasive interface (e.g., tracheostomy tube). Non-invasive volume ventilators are laptop sized, designed for homecare and allows maximum mobility.

Pressure ventilators weigh about 12.4 pounds which enables the user to be mobile and contain pressure control, pressure support and flow triggering features. These devices decrease the work of breathing while increasing patient comfort.

Prior Authorization

The procedure code requires PA. (See Section 14.3.1 Authorization for Durable Medical Equipment)

Documentation

Volume ventilator and pressure ventilators are covered for children with an EPSDT screening when prescribed by a physician as medically necessary:

The recipient must meet **all** of the following conditions:

- Medically dependent on a ventilator for life support at least 6 hours a day
- Dependent for at least 30 consecutive days (or the maximum number of days authorized under the State Plan, whichever is less) as an inpatient in one or more hospitals, NFs, ICFs, or IID;
- Except for the availability of respiratory care services (ventilator equipment) would require respiratory care as an inpatient in a hospital, NF, ICF, or IID and would be eligible to have payment made for inpatient care under the state plan.
- Adequate social support services to be cared for at home are available.
- Receives services under the direction of a physician who is familiar with the technical and medical components of home ventilator support, and who has medically determined that in-home care is safe and feasible for the individual

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without continuous technical or professional supervision. (Reference 42 CFR Section 440.185 Respiratory care for ventilator-dependent individuals.)

AND

Patient has at least **one** or more of the following conditions:

a. Chronic respiratory failure,
b. Spinal cord injury,
c. Chronic pulmonary disorders,
d. Neuromuscular disorders, or
e. Other neurological disorders and thoracic restrictive diseases.

Initial approval will be allowed for up to 12 months based on the EPSDT screening.

Subsequent approvals will require documentation from the prescriber which substantiates that the recipient continues to meet the medical criteria and indicate the recipient's overall condition has not improved sufficiently.

The ventilator will be reimbursed as a monthly rental item. The monthly rental includes delivery, in-service for caregiver, maintenance, a backup ventilator, back up battery, all medically necessary supplies, and repairs and on call service as necessary. Recertification is required until the recipient no longer meets the criteria or the device is removed from the home. If the ventilator is no longer medically necessary (i.e., the criteria is no longer met) it will be returned to the supplier.

14.2.21 Continuous Positive Airway Pressure (CPAP) Device

E0601 Continuous Positive Airflow Pressure (CPAP) devices are designed to deliver slightly pressurized air to keep the throat open during the night. The device itself weighs about five pounds and fits on a bedside table. A mask containing tubing connects to the device and fits over the nose. Air is delivered by a mask covering the nose or through prongs that fit inside the nose. In addition, the machine supplies a steady stream of air through the tubes and applies sufficient air pressure to prevent tissues in the airway from collapsing during sleep when a person inhales.2

Prior Authorization

CPAP therapy is covered through the EPSDT Program for children up to the age of 21 and requires PA.

Documentation

Diagnosis must be documented by a sleep study performed by a registered or approved sleep laboratory. CPAP therapy is considered medically appropriate if the conditions listed below are met and the documentation requirements listed below are submitted.

A physician specializing in either pulmonology or neurology, or a board certified sleep specialist must document that the recipient meets **all** of the following conditions:

1. Recipient is diagnosed with obstructive sleep apnea, upper airway resistance syndrome, or mixed sleep apnea; and
2. Adenotonsillectomy has been unsuccessful in relieving OSA; or
3. Adenotonsillar tissue is minimal, or
4. Adenotonsillectomy is inappropriate based on OSA being attributable to another underlying cause (e.g., septum deviations, facial abnormalities (craniofacial syndromes), obesity, cardiopulmonary or metabolic disorders, tracheomalacia, tracheostomy complications or other anomalies of the larynx, trachea and bronchus; or when adenotonsillectomy is contraindicated.

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The following documentation also must be submitted:

1. A sleep study must be done within six months of prescribing CPAP therapy; and
2. The sleep study results are recorded for at least 360 minutes or six hours. A sleep study is acceptable for patients less than six months old if the duration of the sleep study is 240 minutes or four hours.

Medicaid will approve the CPAP based on the EPSDT Screening.

Reimbursement

Effective August 1, 2022, the CPAP will be considered a purchased item. No additional payment will be made by Alabama Medicaid on the CPAP machine and the machine will be considered to be owned by the recipient. The purchase payment will include delivery, in-service for the caregiver, maintenance and repair.

Supplies for CPAP Device - A7030, A7031, A7032, A7033, A7034, A7035, A7036, A7037, A7038, A7039, A7044 and A7046

Effective March 6, 2020, CPAP and humidifier devices (heated and non-heated) billed on the same date of service will be reimbursed seperately. Effective August 1, 2022, the humidifier will be reimbursed as a purchase when billed with a CPAP.

NOTE:

Upon initial approval of the CPAP device, recipients may need to try more than one mask to maximize effectiveness of the device. Trial of various masks will be considered as covered in the rent to purchase price and no additional reimbursement is available.

14.2.22 Bilateral Positive Airway Pressure (BI-PAP) Device

E0470, **E0471, E0472:** The Bilateral Positive Airway Pressure (BI-PAP) devices are designed to deliver pressured air to keep the throat open during the night. A mask containing tubing connects to the device and fits over the nose. The machine supplies two levels of pressure through the tube, one for inhaling and one for exhaling. In addition, the machine applies sufficient air pressure to prevent tissues in the airway from collapsing during sleep when a person exhales.

Prior Authorization

The BI-PAP device is covered for children under the age of 21 through the EPSDT screening Program and requires PA.

Documentation

BI-PAP therapy is considered medically appropriate if **all** of the following criteria are met in addition to the documentation requirements:

A. A sleep study with subsequent failure on CPAP therapy is required for patients prescribed therapy for obstructive sleep apnea syndrome, or mixed sleep apnea unless the patient is five years of age or younger.

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B. A physician specializing in either pulmonology, neurology or a board certified sleep specialist, must document that the recipient has one of the following diagnosis:

1. Patient is diagnosed with central or obstructive sleep apnea, (sleep study required),
2. Patient is diagnosed with upper airway resistance syndrome, (sleep study required),
3. Patient is diagnosed with mixed sleep apnea, (sleep study required), or
4. Patient is diagnosed with a neuromuscular disease (examples include muscular dystrophies, myopathies, and spinal cord injuries), respiratory insufficiency or restrictive lung disease from wall deformities (sleep study not required)

The following documentation is required if a sleep study was indicated:

1. The sleep study must be done within six months of prescribing BIPAP Therapy.
2. The results of a sleep study recorded for at least 360 minutes or six hours must be submitted. A sleep study is acceptable for patients less than six months old if the duration of the sleep study is 240 minutes or four hours.

Initial approval will be considered a purchased item for any qualified Medicaid recipient who meets the above criteria. The information submitted must include documentation that the recipient meets the above medical criteria. After initial approval, BIPAPs will be considered purchased and owned by the recipient.

Reimbursement

Effective July 1, 2022, the BIPAP will be considered a purchased item. No additional payment will be made by Alabama Medicaid on the BIPAP machine and the machine will be considered to be owned by the recipient. The purchase payment will include delivery, in-service for the caregiver, maintenance, and repairs. Supplies will be covered up to the maximum allowed units for the specified timeframe as indicated on the DME fee schedule. BI-PAP devices will be limited to one per recipient every eight years.

Effective January 1, 2014, DME Providers submitting PAs for dates of service on or after January 1, 2014:

- Will no longer be reimbursed for the BI-PAP and the humidifier devices separately when billed on the same date of service.
- Will no longer be reimbursed for humidifier devices as a continuous rental when billed with BI-PAP procedure codes E0470, E0471 & E0472

Supplies for BI-PAP Device - A7030, A7031, A7032, A7033, A7034, A7035, A7036, A7037, A7038, A7039, A7044, A7046, and E0565

NOTE:

Upon initial approval of the BI-PAP device recipients may need to try more than one mask to maximize effectiveness of the device. Trial of various masks will be considered as covered in the rent to purchase price and no additional reimbursement is available.

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14.2.23 Home Phototherapy

E0202 Home phototherapy is a covered service in the DME Program for neonatal jaundice, is frequently used for management of physiologic hyperbilirubinemia. The infant is exposed to continuous ultraviolet light via a lamp used in the home for a prescribed period of time. The ultra violet light helps to reduce elevated bilirubin levels which can cause brain damage.

Prior authorization

PA for Home Phototherapy for the first four consecutive days of therapy is no longer a requirement.

If more than four consecutive days of therapy are needed, requests for additional days must be submitted with medical documentation justifying the need to the Clinical Services & Support Division Medical Quality and Review Unit at Medicaid for review and approval. If approval is granted, the Clinical Services & Support Division Medical Quality and Review Unit will notify the provider with billing instructions.

The use of Home phototherapy for children under age 21 is considered medically appropriate if all of the following criteria are met:

1. The infant is term (37 weeks of gestation or greater), older than 48 hours and otherwise healthy;
2. The serum bilirubin levels > 12;
3. The serum bilirubin level is not due to a primary liver disorder;
4. The diagnostic evaluation (described below) is negative; and
5. The infants' bilirubin concentrations as listed below indicate consideration of phototherapy

AGE, HOURS	Consider phototherapy when total serum bilirubin is:
25-48	Greater than 12 (170)
49-72	Greater than 15 (260)
Greater than 72	Greater than 17 (290)

NOTE: These are recommendations for phototherapy for inpatient and outpatient use

NOTE:
An EPSDT screening is not required.

Diagnostic evaluation

Prior to therapy, a diagnostic evaluation should include:

- History and physical examination;
- Hemoglobin concentration or hematocrit;
- WBC count and differential count;
- Blood smear for red cell morphology and platelets;
- Reticulocyte count;
- Total and direct-reacting bilirubin concentration;
- Maternal and infant blood typing and Coombs test; and

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- Urinalysis includes a test for reducing substances.

Documentation

Documentation from the prescriber should indicate the duration of treatment, frequency of use per day and the maximum number of days for home phototherapy. A registered nurse with active license must perform home visits for professional services associated with phototherapy. Providers must submit written verification to the Medicaid agency which includes the nurse's name and license number with an effective date and expiration date for the nurse's license. The provider must assure that the parent or caregiver receives education for the safe and effective use of the home phototherapy equipment. The procedure code (E0202) used for phototherapy includes a global fee per day for equipment, nurse visits, and collection of lab work.

NOTE:

A skilled nursing visit may not be billed in the Home Health program for this service.

14.2.24 High Frequency Chest Wall Oscillation Air Pulse Generator System (Includes Hoses and Vest)

E0483 A high frequency chest wall oscillation (HFCWO) system is an airway clearance device consisting of an inflatable vest connected by two tubes to a small air-pulse generator that is easy to transport. Request for the HFCWO must be received by Medicaid's Fiscal Agent within thirty calendar days after the equipment is dispensed.

Prior Authorization

This procedure code requires PA. (See Section 14.3.1 Authorization for Durable Medical Equipment)

Documentation

The HFCWO is covered for EPSDT referred recipients when prescribed as medically necessary and **all** of the following criteria are met:

1. The patient has had two or more hospitalizations or episodes of home intravenous antibiotic therapy for acute pulmonary exacerbations during the previous twelve months; and
2. The FEV1 (forced expiratory flow in one second) is less than 80% of predicted value or FVC (forced vital capacity) is less than 50% of the predicted value; and
3. There is a prescribed need for chest physiotherapy at least twice daily; and
4. There is a well-documented failure of other forms of chest physiotherapy which have been demonstrated in the literature to be efficacious, including hand percussion, mechanical percussion, and Positive Expiratory Pressure (PEP) device. The evidence must show that these have been tried in good faith and been shown to have failed prior to approval of the vest; and
5. The patient does not have a caretaker available or capable of assisting with hand percussion, then a trial of hand percussion would not be a necessary prerequisite, but such patients would still need to in good faith complete a trial of mechanical percussion and the use of the PEP device.

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NOTE:

The qualifying diagnosis for the HFCWO system is Cystic Fibrosis (277.00, 277.02 for ICD-9 and E84.9 and E84.0 for ICD-10.

Medicaid Coverage for the HFCWO (Capped Rental)

The initial rental approval will consist of up to 90 days. A monthly rate will be paid to the provider for the first three months. The rental period will allow the patient to demonstrate compliance with the device. At the end of the 90 days, documentation (requires an additional PA) is required that demonstrates recipients usage and compliance levels. The device must have been used at least 67% of the time. If patient compliance is shown in the first three month rental period, in the fourth month, the device will transition to a purchase, with the total rental payments during the first three months payment and subsequent one month payment equaling the purchase rate. The first three months payment should be billed with the RR modifier. The final purchase payment should not be billed with a modifier.

The rental will include all accessories necessary to use the equipment, education on the proper use and care of the equipment as well as routine servicing, necessary repairs and replacements for optimum performance of the equipment. The monthly payment will include delivery, in-service for the caregiver, maintenance and repair. After the device is purchased no additional cost will be incurred by the Medicaid Agency because the device (the inflatable vest, generator and hoses) is covered under lifetime warranty and the responsibility of the manufacturer or supplier to provide maintenance or replace the device.

Recertification is required until the recipient no longer meets the criteria, the device is removed from the home, or the device is purchased. Recertification criteria submitted should include a current prescription, documentation of continuing medical necessity, compliance and that the recipient's respiratory status is stable or improving. If the HFCWO is determined not to be medically necessary (i.e., the criteria are no longer met) the HFCWO will be returned to the supplier if the total rental amount paid is less than the established purchase price.

Percussor Electric or Pneumatic

Chest percussors, electric or pneumatic, are used to mobilize secretions in the lungs. Chest percussions may be performed by striking the chest with cupped hands or with a mechanical hand held unit. An electric percussor is a vibrator that produces relatively course movements to the chest wall to mobilize respiratory tract secretions and stimulate the cough mechanism.

(See section 14.3.1 Authorization for Durable Medical Equipment)

The percussor is considered medically necessary for patients with excessive mucus production and difficulty clearing secretions if the following criteria are met:

- Must be an EPSDT Medicaid eligible individual;
- Patient has a chronic lung condition of cystic fibrosis or bronchiectasis;
- Other means of chest physiotherapy such as hand percussion and postural drainage have been used and failed;

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- No caregiver available or caregiver is not capable of performing manual therapy; and
- Clinical documentation indicates that manual therapy has been used and does not mobilize respiratory tract or the patient cannot tolerate postural drainage.

14.2.25 Incontinence Products and Supplies (Disposable Diapers)

Medicaid will consider payment of disposable diapers as a personal comfort item if EPSDT referred and/or the patient is currently enrolled in the ID and/or LAH Waiver Special Waiver Program.

Prior Authorization

The applicable procedure codes for disposable diapers require PA. (See Section 14.3.1 Authorization for Durable Medical Equipment)

Documentation

Medicaid will consider payment of disposable diapers when referred as medically necessary from an EPSDT screening and the criteria below are met:

1. Recipient must be at least three years old;
2. Patient must be non-ambulatory or minimally ambulatory; and
3. Patient must be medically at risk for skin breakdown, which is defined as meeting at least **two** of the following:

    a. Unable to control bowel or bladder functions,

    b. Unable to utilize regular toilet facilities due to medical condition,

    c. Unable to physically turn self or reposition self, or

    d. Unable to transfer self from bed to chair or wheelchair without assistance.

If a child (age 3 to 21) is fully ambulatory, but due to his/her mental status/cognitive or developmental disability, the child is unable to assist in his/her toileting needs, documentation of the extraordinary need must be submitted.

Limitations:

T4521	Adult-sized incontinence product, diaper, small	180 units per month
T4522	Adult-sized incontinence product, diaper, medium	180 units per month
T4523	Adult-sized incontinence product, diaper, large	150 units per month
T4524	Adult-sized incontinence product, diaper extra large	150 units per month
T4529	Child-sized incontinence product, diaper small/medium	210 units per month
T4530	Child-sized incontinence product, large	210 units per month
T4533	Youth-sized incontinence product, brief/diaper	210 units per month
T4543	Adult-size incontinence brief/diaper, above extra-large	150 units per month

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Exceptions:

EPSDT recipients may receive name brand diapers at an increased reimbursement rate. The following procedure codes **with an SC modifier** should be used when approving PAs for name brand diapers:

T4521	Adult-sized incontinence product, diaper, small	120 units per month
T4523	Adult sized incontinence product, diaper, large	120 units per month
T4524	Adult sized incontinence product, diaper, extra large	120 units per month
T4530	Child sized incontinence product, diaper, large	100 units per month
T4533	Youth Size incontinence product, brief/diaper, each	120 units per month

Special Waiver Patients:

ID and LAH Waiver patients are also able to receive the following items:

A4553 Non-disposable under pads, all sizes

A4554 Disposable under pads, all sizes

A4927 Non-sterile gloves

A9286 Any hygienic item, device (i.e. Baby wipes)

T4535 Disposable liner/shield/pad

T4545 Incontinence disposable penile wrap

14.2.26 Apnea Monitor

E0619 The apnea monitor is a covered service with PA 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.

Prior Authorization

This procedure code requires PA. (See Section 14.3.1 Authorization for Durable Medical Equipment)

Documentation

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 pathologic apnea).
- Pre-term infants with periods of pathologic apnea
- Sibling of SIDS victim
- Infants with neurological conditions that cause central hypoventilation

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- 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 prescriber 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 or 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. The staff providing CPR training must have a license or certification to provide such training.
    - It is the DME provider's responsibility to ensure that parents provide them with documentation of CPR training.
    - It is not the provider's responsibility to provide CPR training to the parents.

Approval is for three 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

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 for ICD-9 and Z76.2 for ICD-10. DME providers should use V201 or Z76.2 only for a recipient who is a sibling of a SIDS victim. Do not use diagnosis code 7980. The clinical statement must include documentation from the physician supporting the recipient's diagnosis of 'Sibling of SIDS victim.'

14.2.27 Enteral Nutrition Equipment and Supplies

B4034, B4036 (EPSDT only)

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A4213, B4035, **B4081, B4082, B4087, B4088, B9002, B9998 (entire Medicaid population)**

Prior Authorization

PA requests are required for most Enteral Nutrition Equipment and Supplies. PA requests must be submitted with verification that all medical criteria have been met. (See Section 14.3.1 Authorization for Durable Medical Equipment)

Documentation

Enteral nutrition equipment and supplies are covered for children under the age of 21 with an EPSDT Screening and Referral.

Recipients age 21 and above (with noted limitations) qualify based on medical necessity and PA when the following criteria are met:

The recipient meets the following criteria for enteral nutrition:

a. Recipient is < age 21 and record supports that > than 50 % of need is met by specialized nutrition; **OR**

b. Recipient is > age 21 and record supports 100 % of need is met by specialized nutrition and provided by tube feedings **AND** must submit documentation from the prescriber to support that the recipient cannot tolerate bolus feeding and requires enteral nutrition by pump.

Enteral nutrition for adults 21 years of age and above is provided through bolus feeds using procedure code A4213

14.2.28 Total Parenteral Nutrition (TPN) Pump and Supplies

B4224 (Parenteral administration kit; per day) is to be used with TPN Therapy.

B4220 (Parenteral nutrition supply kit; premix, per day) or B4222 (Parenteral nutrition supply kit; home mix, per day) may be used in conjunction with B4224. However, at no time should both B4220 and B4222 be billed on the same date of service with procedure code B4224.

Prior Authorization

TPN pumps (B9004, B9006) are provided for all Medicaid recipients and require PA.

TPN supplies (E0776, B4224, B4220 and B4222) do not require PA.

Documentation

All TPN supplies are provided to Medicaid recipients based on medical necessity when the following criteria are met:

1. The recipient meets the criteria for total parenteral nutrition (TPN)
   a. Recipient < age 21 and record supports that > than 50% of need is met by specialized nutrition, or
   b. Recipient > age 21 and record supports 100% of need is met by specialized nutrition.
2. The recipient cannot be sustained through oral feedings and must rely on enteral nutrition therapy which is administered by some form of intravenous therapy.
3. Verification that the criteria have been met must accompany the PA request.

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E0776: If procedure code E0776 (IV Pole) is needed for a period of more than six months this is considered long term and should be billed as a purchased item. Procedure code E0776 may be rented short term for up to six months or less.

14.2.29 Home Infusion Therapy Services Equipment and Supplies

Home Infusion Therapy **(**HIT**)** includes administration of medication and nutrients and the associated supplies, provided to Medicaid recipients residing in a private residence. Infusion therapy is a procedure that involves the insertion of a catheter into a blood vessel providing a painless way of drawing blood, delivering drugs and nutrients into a patient's bloodstream over a period of weeks, months or even years. Common uses for intravenous therapy are intravenous antibiotic treatment, chemotherapy, hydration and pain management therapy.

HIT components can be provided and billed by enrolled DME Pharmacies and DME Infusion providers only as described in the HIT policy. DME Home Infusion providers must be accredited by a nationally recognized accrediting body in order to be reimbursed for home infusion therapy services. Providers must submit sufficient proof of accreditation during initial provider enrollment and re-validation process.

Documentation

HIT must be prescribed by the prescriber as a medically necessary health care service. The prescriber's orders must clearly document the starting date for care, expected duration of therapy, the amount and types of services required. If the recipient requires multiple drug therapies, the therapies must be provided by the same agency. The medication administration record and or the nursing documentation should coincide with the billing based on the time of completion and discontinued use of the drug that required the need for durable medical supplies. The recipient's record must have medical documentation justifying medical necessity.

HIT services billed using the S codes include, antibiotic, antiviral or antifungal therapy (S9500; S9501, S9502, S9503 and S9504), hydration therapy (S9373), chemotherapy (S9330), pain management therapy (S9326), specialty infusion therapies such as anti-coagulant (S9336), antiemetic (S9351), catheter care (S5498, S5501), and catheter insertion (S5520 and S5521). These "S" codes include administrative services, professional pharmacy services, care coordination **and all necessary supplies and equipment (including pump)**. Drugs and nursing visits are billed separately.

Prior Authorization

The "S" codes listed in this paragraph **do not** require PA.

Catheter Care

S5498 (1 unit; limited to 31 units per month; must be billed 1 unit per day)

Home Infusion Therapy, Catheter Care/ Maintenance, simple (single lumen), includes administrative services, professional pharmacy services, care coordination, **and all necessary supplies and equipment** (drugs and nursing visits coded separately)

S5501 (1 unit; limited to 31 units per month; must be billed 1 unit per day)

Home Infusion Therapy, Catheter Care/ Maintenance, complex (more than one lumen), includes administrative services, professional pharmacy services, care coordination,

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and all necessary supplies and equipment (drugs and nursing visits coded separately)

S5520 (1 unit; limited to 5 units per month; must be billed 1 unit per day)

Home Infusion Therapy, **all supplies** (including catheter) necessary for peripherally inserted central venous catheter (PICC) line insertion

S5521 (1 unit; limited to 5 units per month; must be billed 1 unit per day)

Home Infusion Therapy, **all supplies** (including catheter) necessary for a midline catheter insertion

The catheter dressing supplies may be reported separately when used as a stand-alone therapy, or during days not covered under another infusion therapy reimbursement rate. PICC line, Port-A-Cath or MediPort dressing supplies including the anchor device is allowed as a separate charge if there is no other therapy in the last 30 days in the home.

Pain Management

S9326 (limited to 31 units per month; must be billed 1 unit per day)

Home Infusion Therapy, continuous (24 hours or more) pain management infusion, includes administrative services, professional pharmacy services, care coordination, **and all necessary supplies and equipment** (drugs and nursing visits coded separately)

Pain management therapy is considered medically necessary when used to administer opioid drugs (e.g., morphine) and/or clonidine intrathecally for treatment of severe chronic intractable pain in persons who have proven unresponsive to less invasive medical therapy. The recipient's record must have medical documentation justifying medical necessity:

Chemotherapy

S9330 (1 unit; limited to 31 units per month; must be billed 1 unit per day)

Home Infusion Therapy, continuous (24 hours or more) chemotherapy infusion includes administrative services, professional pharmacy services, care coordination, **and all necessary supplies and equipment** (drugs and nursing visits coded separately)

The recipient's record must have medical documentation justifying medical necessity.

Anticoagulant Therapy

S9336 (1 unit; limited to 31 units per month; must be billed 1 unit per day)

Home Infusion Therapy, continuous anticoagulant infusion therapy (e.g., heparin), includes administrative services, professional pharmacy services, care coordination, **and all necessary supplies and equipment** (drugs and nursing visits coded separately)

Antibiotic, Antiviral or Antifungal Therapy

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Effective for dates of service on or after June 1, 2014, DME Provider(s) billing for Antibiotic, Antiviral or Antifungal Therapy procedure code(s) S9500, S9501, S9502, S9503 and S9504 must bill with the "SQ" modifier. **S9500** (1 unit; limited to 31 units per month; must be billed 1 unit per day)

Home Infusion Therapy, antibiotic, antiviral, or antifungal therapy; once every 24 hours; includes administrative services, professional pharmacy services, care coordination, **and all necessary supplies and equipment** (drugs and nursing visits coded separately),

S9501 (1 unit; limited to 31 units per month; must be billed 1 unit per day)

Home Infusion Therapy, antibiotic, antiviral**,** or antifungal therapy; once every 12 hours; includes administrative services, professional pharmacy services, care coordination, **and all necessary supplies and equipment** (drugs and nursing visits coded separately)

S9502 (1 unit; limited to 31 units per month; must be billed 1 unit per day)

Home Infusion Therapy, antibiotic, antiviral**,** or antifungal therapy; once every 8 hours; includes administrative services, professional pharmacy services, care coordination, **and all necessary supplies and equipment** (drugs and nursing visits coded separately)

S9503 (1 unit; limited to 31 units per month; must be billed 1 unit per day)

Home Infusion Therapy, antibiotic, antiviral, or antifungal therapy; once every 6 hours; includes administrative services, professional pharmacy services, care coordination, **and all necessary supplies and equipment** (drugs and nursing visits coded separately)

S9504 (1 unit; limited to 31 units per month; must be billed 1 unit per day)

Home Infusion Therapy, antibiotic, antiviral, or antifungal therapy; once every 4 hours; includes administrative services, professional pharmacy services, care coordination, **and all necessary supplies and equipment** (drugs and nursing visits coded separately)

Intravenous Immune Globulin (IVIG) Therapy

Effective for dates of service on or after June 1, 2014, Intravenous Immune Globulin (IVIG) Therapy must be billed with a diagnosis code in the range from 279.00 through 279.06, 279.10, 279.2 and 279.12 for ICD-9, and for ICD-10 bill D80.0 through D80.5, D81.0 through D81.2, D81.6 through D81.7, D81.89 through D81.9, D82.0; D83.0 through D83.2; D83.8 through D83.9 and G61.0 with procedure codes : S9500, S9502, S9503, S9504 or S9338. For non-covered diagnosis codes, a prior authorization and peer reviewed medical literature can be submitted and will be reviewed for medical neccessity.

The following procedure codes must be used to bill for Intravenous Immune Globulin (IVIG) therapy:

S9500 (1 unit: limited to 31 units per month; must be billed 1 unit per day)
S9502 (1 unit: limited to 31 units per month; must be billed 1 unit per day)
S9503 (1 unit: limited to 31 units per month; must be billed 1 unit per day)
S9504 (1 unit: limited to 31 units per month; must be billed 1 unit per day)

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S9338 (1 unit; limited to 31 units per month; must be billed 1 unit per day)

In addition, the derivative must be administered in the home of the recipient and the physician must determine that it is medically necessary. This service includes administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment. Drugs and nursing visits are to be coded separately.

Prior Authorization

If the recipient does not have one of the required diagnoses or the units exceed the allowable amount, the provider must obtain PA. See Section 14.3.1 Authorization for Durable Medical Equipment)

Hydration Therapy

S9373 (1 unit; limited to 31 units per month; must be billed 1 unit per day)

Home Infusion Therapy, hydration therapy includes administrative services, professional pharmacy services, care coordination, **and all necessary supplies and equipment** (drugs and nursing visits coded separately), (do not use with hydration therapy codes S9374-S9377 using daily volume scales),

Hydration therapy is considered medically necessary for recipients who become dehydrated due to illness, surgery, or accident. Dehydration occurs when patients are losing necessary fluids at a rate faster than they are retaining fluids. The recipient's record must have medical documentation justifying medical necessity.

Anti-emetic Therapy

S9351 (1 unit; limited to 31 units per month; must be billed 1 unit per day)

Home Infusion Therapy, continuous or intermittent anti-emetic infusion therapy; includes administrative services, professional pharmacy services, care coordination, **and all necessary supplies and equipment** (drugs and nursing visits coded separately)

Anti-emetic therapy is typically used to treat motion sickness and the side effects of opioids analgesics, general anesthetics and chemotherapy directed against cancer. The anti-emetic assists the recipient in preventing or alleviating irretractable nausea and vomiting. The recipient's record must have medical documentation justifying medical necessity.

S9347 (1 unit; limited to 31 units per month; must be billed 1 unit per day)
Home Infusion Therapy, uninterrupted, long-term, controlled rate Intravenous or subcutaneous infusion therapy (e.g. epoprostenol); includes administrative services, professional pharmacy services, care coordination, **and all necessary supplies and equipment** (drugs and nursing visits coded separately).

S9490 (1 unit; limited to 31 units per month; must be billed 1 unit per day)
Home Infusion Therapy, corticosteroid infusion; includes administrative services, professional pharmacy services, care coordination, **and all necessary supplies and equipment** (drugs and nursing visits coded separately).

Home Infusion Otherwise Classified (S9379)

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Home Infusion Therapy, infusion therapy not otherwise classified; includes administrative services, professional pharmacy services, care coordination, **and all necessary supplies and equipmen**t (drugs and nursing visits coded separately)

Anticipating that new infusion therapies will be developed or that a current therapy has been overlooked, the Clinical Services & Support Division Medical and Quality Review Unit will consider authorization of other therapies on an individual basis. These special requests will require peer reviewed medical literature documentation and medical review.

Prior Authorization

This procedure code requires PA. (See Section 14.3.1 Authorization for Durable Medical Equipment)

Limitations

Drugs and nursing visits for home infusion are coded separately.

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14.2.30 Cough Stimulating Devices (E0482)

Medicaid will provide coverage of the Cough Stimulating Devices for children under the age of 21 through the EPSDT program if all of the following criteria are met:

1. Patient has a neuromuscular disease such as polio, multiple sclerosis, quadriplegia or significant impairment of chest wall and/or diaphragmatic movement such that it results in an inability to clear retained secretions **AND**

2. Patient is cognitively intact, or has a caregiver who is capable, physically and intellectually of operating the CSD effectively.

Limitations

- The Cough Stimulating Device will be covered as a capped rental item. The initial rental approval will consist of up to 6 months before purchase of the equipment under the 10 month capped rental plan.
- At the end of the 6 month period, the physician must submit documentation of continued medical necessity, evidence of recipient/caregiver compliance an improved diseased management since beginning use of the cough-stimulating device as indicated by few infections requiring antibiotics and fewer hospitalizations. A new prior authorization (PA) must be submitted at the end of the six months period.
- If approval is granted for an additional 4 months, the equipment becomes a capped rental item. At the end of the 10 month period the device is considered to be a purchased item paid for in full by Medicaid. Any maintenance or repair cost would be subject to an EPSDT screening and referral and a PA.

14.2.31 Prosthetic, Orthotic and Pedorthic Devices

Basic level prosthetics, orthotics and pedorthics are covered benefits to Medicaid eligible recipients up to age 65 in a non-institutional and institutional setting. Children below the age of 21 are covered through the EPSDT Program.

A prosthetic device is an artificial substitute that replaces all or part of a body organ, or replaces all or part of the function of a permanently inoperative, absent or malfunctioning body part. Lower limb prostheses may include a number of components, such as prosthetic feet, ankles, knees, endoskeletal knee-shin systems, limb-ankle prostheses, socket insertions and suspensions. Pedorthic is the making and fitting of shoes and other foot support products to alleviate and prevent foot injury and disease.

Orthotic devices are fabricated, fitted or modified devices to correct or compensate for a neuro-musculoskeletal disorder or acquired condition (in other words braces for the body, excluding teeth). The orthotic device may be custom fabricated and fitted, prefabricated custom fitted or off-the-shelf if prefabricated and fitted.

Prior Authorization

Unless specified on the DME Fee schedule, these devices DO NOT REQUIRE PA.

Documentation

For items to be covered recipients must meet eligibility requirements, the devices must be reasonable and necessary to improve the functioning of a malformed body member

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or replace an absent body member, and meet all other applicable Medicaid statutory and regulatory requirements.

The provider must be practicing as a prosthetic, orthotic or pedorthic practitioner in the State of Alabama at an accredited facility. Providers must keep a copy of the written and signed prescription or order from the primary physician for the prosthetic or orthotic device in the recipient's file for a period of three years plus the current year. The provider must also have documentation of the education and follow-up provided to the recipient of the use of the prosthetic and orthotic device in the recipient's file.

Coverage Information

For Medicaid to approve lower limb prosthesis, medical documentation must be maintained in the supplier's recipient file substantiating that prosthesis is essential in order for the recipient to ambulate and that the recipient is motivated to ambulate.

For Medicaid to approve an orthotic device, medical documentation must be maintained in the supplier's recipient file to show that the device supports or aligns movable parts of the body, prevent or correct deformities, or improve functioning.

For Medicaid to approve therapeutic shoes for diabetes, medical documentation must be maintained in the supplier's recipient file showing that the recipient has diabetes mellitus and other medical conditions justifying the need.

Refer to the DME Fee Schedule on the Alabama Medicaid website for Prosthetic, Orthotic, and Pedorthic reimbursement rates and benefit limits.

14.2.32 Prosthetic, Orthotic and Pedorthic Devices Covered for Medicaid Recipients age 21 and above

Lower Limb Prostheses Codes – L5301, L5321, L5620, L5624, L5629, L5631, L5649, L5650, L5655, L5685, L5695, L5700, L5701, L5704, L5705, L5812, L5850, L5910,L5940, L5950, L5962, L5964, L5972, L5974, L5920

Prosthetic related Supplies Codes - L8400, L8410, L8420, L8430, L8470, L8480

Prosthetic related supply codes are covered if a recipient is an amputee, has a prosthetic leg, and these supplies are necessary for the function of the prosthetic.

Orthotic Basic Codes – L1930, L1960, L1970, L1990, L2020, L2405
Ankle-foot orthoses (AFO) codes L1930, L1960, L1970, L1990 and knee-ankle foot orthoses (KAFO) codes L2020 and L2405 are covered for ambulatory recipients with weakness or deformity of the foot and ankle, which requires stabilization for medical reasons, and have the potential to benefit functionally. Knee-ankle foot orthoses (KAFO) are primarily covered for ambulatory recipients that require additional knee stability and would not benefit from the AFO.

Therapeutic Shoe Codes for Diabetes – A5500, A5513, A5501
Addition to Lower Extremity Orthosis, Shoe-Ankle-Shin-Knee- L2220
Additions General - L2795
Additions, Socket Variations - L5651, L5652
Additions, Socket Insert and Suspensions – L5671, L5673, L5679
Additions, Endoskeletal Knee-Shin System - L5986
Prosthetic Socks: L8440, L8460
Wrist-Hand-Finger Orthosis – L3807

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Orthosis Devices Spinal – L0472, L0458
Transfer or Replacement – L3610
Orthotic Devices, Spinal – L0172
Thoracic – L0486
Cervical-Thoracic-Lumbar-Sacral Orthosis (CTLSO) – L0628 must be billed with a CG modifier for age 21-65, L0630, L0640
Additions to Spinal Orthosis – L0984

14.2.33 External Breast Prostheses

(1) External breast prostheses following mastectomy for breast cancer are covered for all Medicaid-eligible recipients meeting the criteria.

(2) Coverage is available for the external breast prostheses when all of the following criteria are met:

(a) Recipient must be eligible for Medicaid on the date of service for provision of prostheses;

(b) The applicable International Classification of Diseases 10th Revision, Clinical Modification (ICD-10-CM) diagnosis code which indicates carcinoma or malignant neoplasm of the breast must be provided.

(c) Effective January 1, 2013, Alabama Medicaid will no longer require PAs for external breast prostheses for artificial breast substitutes covered under the Durable Medical Equipment program. The appropriate procedure codes are billed as indicated below:

Procedure Code	Description	Limits
L8000	Breast prosthesis, mastectomy bra Maximum of 4 on initial request	6/year
L8015	External breast prosthesis garment, with mastectomy form	2/year
L8020	Breast prosthesis, mastectomy form	**
L8030	Breast prosthesis, silicone or equal	**
L8035	Custom breast prosthesis, post mastectomy, molded to patient model	
L8039	Breast prosthesis, not otherwise classified Evaluated on a case-by-case basis with submission of pricing information and medical documentation	

Limited to two of **L8020 or **L8030** per year, or one **L8020** and one **L8030** per year.
(3) Maximum calendar year limits apply to each of the procedures as indicated above.

(4) Providers of external breast prostheses devices for adults must be enrolled as a Medicaid provider and Mastectomy Fitters must be licensed by the Alabama Board of Prosthetics, Orthotics and Pedorthics.

For reimbursement rates and benefit limits for the Prosthetic, Orthotic and Pedorthic procedure codes, refer to the DME fee schedule.

14.2.34 Controlled Dose Drug Inhalation System (K0730)

Alabama Medicaid covers **K0730**. This code is a ten month capped rental to purchase item and at the end of the ten month rental period the device will be a purchased item for the recipient.

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This procedure code does not require PA.

Documentation

The drug delivery system will only be covered for eligible Medicaid recipients currently receiving the drug Ventavis. Alabama Medicaid must currently be reimbursing for this drug for these recipients. Providers will be required to submit claims with one of the following diagnosis codes 415.0, 416.0, and 416.8 for the controlled dose inhalation drug delivery system. If it is determined through provider audits that providers are not billing procedure code K0730 in accordance with Medicaid's policy guidelines, Medicaid payments for this service will be recouped.

Repairs

Repairs for this system will be covered using procedure code E1399. All repair cost must be submitted with itemized provider invoice cost. Repairs will be reimbursed at provider's cost plus 20%. The reimbursement amount will be calculated based on the provider's **final invoice** after all discounts have been applied.

14.2.35 Tracheostomy Supplies

Alabama Medicaid covers tracheostomy supplies for eligible Medicaid recipients when prescribed as medically necessary by the physician.

A4605 Tracheal suction catheter, closed system, each

A7008 Large volume nebulizer, disposable, prefilled, used with aerosol compressor (neb adapters)

A7010 Corrugated tubing, disposable, used with large volume nebulizer, 100ft (aerosol tubing)

A7012 Water collection device, used with large volume nebulizer (drain bag)

A9900 Miscellaneous DME supply, accessory, or service component of another HCPCS code (suction machine bacteria filters)

S8999 Resuscitation bag (for use by patient on artificial respiration during power failure or other catastrophic event (resuscitation bags)

Prior Authorization

The above listed supplies do not require PA but there are quantity restrictions. See DME Fee Schedule for quantity restrictions.
A7509 Filter holder and integrated filter housing, and adhesive, for use as a tracheostomy heat moisture exchange system.

S8189 Tracheostomy supply, not otherwise classified will be used to bill for the customized or specialty trachs.
E1399 Peep valves and Respigard filters will be billed using miscellaneous code E1399. Any other trach supply items requested must be submitted using miscellaneous procedure code E1399. Medical documentation and provider's invoice must be submitted for review and approval. Medicaid will reimburse these trach supplies at provider's invoice price plus 20%. The reimbursement amount will be calculated based on the provider's **final invoice** after all discounts have been applied.

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14.2.36 Transfer Boards

E0705 Medicaid will consider coverage of transfer boards when prescribed as medically necessary by the recipient's primary care physician. Transfer boards will be approved for Medicaid eligible recipients with medical conditions that limit their ability to transfer from a wheelchair to a bed, chair, toilet, etc. Medical documentation should indicate that the recipient is immobile and requires assistance.

14.2.37 Special Ostomy Supplies

A4421 Special ostomy supplies should be submitted using procedure code A4421 with an SC modifier.

Prior Authorization

Special ostomy supplies will require PA. All PA requests will be approved based on the submitted quantity limitations prescribed by the physician and medical documentation justifying the need. Special ostomy supplies will be reimbursed at provider's invoice price plus 20% and will pay from the approved price listed on the PA file.

Effective for dates of service on or after April 1, 2023, Alabama Medicaid Agency will cover the below ostomy supply procedure codes. The procedure codes listed below will be subject to maximum allowed units per year. For reimbursement rates and benefit limits, refer to the DME Fee Schedule.

Procedure code	Procedure code description	Maximum allowed units
A4407	Ext wear ost sknbarr <=4SQ"	2 units per week/104 units per year
A4409	Ost skin barr convex <=4 SQ I	2 units per week/104 units per year
A4408	Ext wear ost skn barr >4SQ"	2 units per week/104 units per year
A4410	Ost skn barr extnd >4 SQ	2 units per week/104 units per year
A5056	1 pc ost pouch w filter	2 units per week/104 units per year
A5057	1 pc ost pou w built-in conv	2 units per week/104 units per year
A4425	Ost pch drain for barrier fl	2 units per week/104 units per year
A4391	Urinary pouch w ex wear barr	2 units per week/104 units per year
A4393	Urine pch w ex wear bar conv	2 units per week/104 units per year
A4428	Urine ost pouch w faucet/tap	2 units per week/104 units per year
A4430	Ost urine pch w b/bltin conv	2 units per week/104 units per year
A4416	Ost pch clsd w barrier/filtr	3 units per week/156 units per year
A4419	Ost pch for bar w flange.flt	3 units per week/156 units per year
A4406	Pectin based ostomy paste	3 units per week/156 units per year
A4413	2 pc drainable ost pouch	2 units per week/104 units per year
A4424	Ost pch drain w bar & filter	2 units per week/104 units per year
A4432	OS pch urine w bar/fange/tap	2 units per week/104 units per year

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A4435	1pc ost pch drain hgh output	2 units per week/104 units per year
A5073	Urinary pouch on barr w/flng	2 units per week/104 units per year
A4371	Skin barrier powder per oz	2 units per year
A4396	Peristomal hernia support blt	2 units per year

14.2.38 Adaptive Strollers, Equipment and Accessories

E1035 Adaptive strollers, equipment and accessories are covered items in the DME program for Medicaid eligible children under the age of 21 through the EPSDT program who meet criteria. Medicaid will reimburse providers at provider's invoice price plus 20%.

Enuresis Alarm

S8270 The enuresis alarm is covered through the DME Program for recipient's age five years up to age 21. Providers should submit their claims for the enuresis alarm using procedure code S8270 and should bill their usual and customary charge for reimbursement.

The American Academy of Family Physicians (AAFP) published recommendation for treatment of enuresis stating there are two first line therapies, enuresis alarm and desmopressin. Providers are encouraged to prescribe the enuresis alarm as a first line and cost effective therapy.

14.2.39 Straight Tip Catheters

Effective January 1, 2023, A4351, A4352, A4353, and A4349 will be limited to 180 catheters per calendar month for all ages. No prior authorization is required.

For each episode of covered catheterization, Medicaid will cover:

- Intermittent urinary catheter straight tip (A4351); or
- Intermittent urinary catheter coude (curved) tip (A4352)
- Intermittent urinary catheter, with insertion supplies (A4353)
- Male external catheter with or without adhesive, disposable, each (A4349).

14.2.40 External Ambulatory Chemotherapy Infusion Pump

An external ambulatory chemotherapy infusion pump is a small portable battery or electrical device worn on a belt around the waist and attached to a needle or catheter designed to deliver measured amounts of chemotherapeutic agents through injection over a period of time. E0781 is used for an external ambulatory infusion pump that is provided in an outpatient cancer facility and the patient takes home to continue administration of chemotherapy.

Coverage Policy for Adults and Children (Defined through EPSDT as 20 years old and younger):
Medicaid will consider payment for an external ambulatory infusion pump when referred as medically necessary and all of the criteria below are met:

1. The patient must have a documented diagnosis of any unspecified cancerous tumor where this disease is unresectable or where the beneficiary refuses surgical excision of

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the tumor. Anticancer chemotherapy drugs used in these conditions are not required to meet the criteria.

2. A board-certified specialist in Oncology (CSO) must have evaluated the patient and ordered the infusion pump.
(Reviewer: Check for notes in patient chart for initial assessment and order of pump by CSO. Follow up/other documentation may be by local physician.)

3. Patient or caregiver must be capable, physically and intellectually, of operating the pump. Patient/caregiver must demonstrate ability and commitment to comply with regimen of pump care and medications.
(Reviewer: Check for physician attestation, notes in patient chart. Education on infusion pump MUST have been conducted prior to prior authorization request, and each the patient, caregiver if child, and educator signed to document their understanding.)

Checklist must be submitted and signed by physician or CSO.

Limitations:
E0781 - External Ambulatory Chemotherapy Infusion Pump will be rented on a monthly basis. The pump will be reimbursed at a monthly rental rate based on the CURES rate listed on the max fee panel.

14.2.41 Cranial Orthoses

S1040 Cranial orthoses involve an adjustable helmet or band that progressively mold the shape of the infant cranium by applying corrective forces to prominences while leaving room for growth in the adjacent flattened areas.

Coverage Information:
Use of an adjustable cranial orthosis may be considered medically necessary following cranial vault remodeling surgery for synostosis. Synostotic deformities associated with functional deficits are addressed by
surgical remodeling of the cranial vault. Use of an adjustable cranial orthosis for synostosis in the absence of cranial vault remodeling surgery is considered not medically necessary.

Documentation:
The following criteria must be met for prior approval of cranial orthses:
1. The practitioner must sign and date the order/prescription to indicate the type of cranial orthoses and the medical reason(s) for its use, **and**
2. The documentation should indicate the recipient had a cranial vault remodeling surgery.

Reimbursement:
The agency will reimburse cranial orthoses as an all-inclusive service, including the helmet, fittings, monthly helmet adjustments, anatomical scans, and payment to the required licensed personnel that perform the adjustments and scans. Providers will be reimbursed their invoice costs, which should not exceed a reimbursement amount of $3,000.

Limitations:
Cranial orthotic helmets are limited to (2) per lifetime.

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14.3 Prior Authorization and Referral Requirements

Certain DME requires PA. Please refer to DME Fee Schedule on Medicaid's website (www.medicaid.alabama.gov) for an inclusive listing of DME items that require PA. Payment will not be made for these procedures unless the PA request is received within **thirty calendar days** after the service is provided.

PA requests for DME, supplies and appliances must include medical records to support the medical necessity of the requested item(s). **Checklists are not sufficient medical documentation.**

NOTE:
Prior authorization is not a guarantee of payment. The authorization number does not guarantee recipient eligibility at the time the equipment is dispensed. The provider is responsible for verifying recipient's eligibility.

When filing claims for recipients enrolled in the ACHN Program, refer to Chapter 40 to determine whether your services require a referral from the PCP.

All requests for prior approval should be initiated and signed by the prescriber and must document medical necessity. Requests may be sent electronically using the Medicaid's fiscal agent software or mailed in hardcopy to the Prior Authorization Unit, P.O. Box 244032, Montgomery, Alabama 36124-4032. Medicaid's PA Contractor will approve or deny the request. Medicaid's Fiscal Agent will return any requests containing missing or invalid information. Please see Chapter 4, Obtaining Prior Authorization, for additional information.

Procedures for changing rendering providers

1. Obtain a written statement from the initial rendering provider indicating that they are aware and agree with the decision of the recipient to change providers and that the approved PA may be cancelled.

2. Confirm this decision with the recipient by having the new provider submit a written statement that they will now be submitting a PA request on the patient's behalf and have the patient sign that they agree and understand.

3. Cancel the approved PA request in the system.

4. Review the new providers request and approve or deny.

14.3.1 Authorization for Durable Medical Equipment

Provider must have a prescription or order on file from the prescriber that a specific covered item of durable medical equipment is medically necessary for use in the recipient's home prior to submitting the PA request electronically. The physician may also fax the prescription or order to the provider of the recipient's choice. The provider must submit pertinent medical information to the Medicaid fiscal agent. Refer to Chapter 4, Obtaining Prior Authorization, for information about the PA process. The fiscal agent will assign a PA tracking number and transmit the request to Medicaid's PA designee for review.

PA requests for purchase, rental, or re-certification of DME must be received by Medicaid's fiscal agent within **thirty calendar days** of the signature date the equipment

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was dispensed. PA requests that are received by Medicaid's fiscal agent and rejected due to incorrect information will not be considered received timely unless resubmitted correctly within thirty days of the dispensed date.

Medicaid will review the request and assign a status of approved, denied, or pending. Providers are sent approval letters indicating the ten-digit PA number that should be referenced on the claim form for billing. Providers and recipients will be notified on denied requests. Providers will be notified of approved requests.

If a PA request is assigned an approved status by Medicaid, only the approved procedure code(s), without alteration(s), can be dispensed to the recipient. If the procedure code on the PA request is incorrect, then the procedure code must be cancelled using Form 471 (PA Change Request) and a new PA submitted for the correct procedure code, However, upon the provider's request, Alabama Medicaid or its designee may approve the replacement of the correct procedure code to the current PA **only** if the previously submitted documentation verifies the correct procedure code.

All prior requests returned to the DME provider by Medicaid or its designee for additional medical information, if resubmitted, must contain the following:

PA requests that are lacking necessary information (EPSDT screening, referrals, required attachment) will be denied and the reason(s) noted in the PA letter under, "Analyst Remarks Request for reconsideration of a denied PA must be received by the fiscal agent within 30 days of the date of the denial letter.

All prior requests denied by Medicaid or its designee for additional medical information, if resubmitted for reconsideration, must contain the following the specific documentation noted on the PA decision letter under "Analyst's Remarks."

PA Forms: For a hardcopy request, the provider or authorized representative must personally sign the form in the appropriate area or place his or her initials next to a typewritten or stamped signature to certify that the requested service, equipment, or supply is medically indicated and is reasonable and necessary for the treatment of the patient, and that a physician signed prescription or order is on file (if applicable). For electronic requests, provider certification will be made via standardized electronic signature protocol.

DME Review Criteria

Medicaid reviews all DME PA requests for the following:

- Medicaid eligibility
- Medicare eligibility
- Medical necessity
- Therapeutic purpose for use of equipment in the recipient's home

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.

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NOTE:

For information on submitting Electronic PA Requests Requiring Attachments refer to Chapter 4, section 4.2.1 (Submitting PAs Using Provider Electronic Solutions) of the Alabama Medicaid Provider Manual.

Disposition of Equipment

The recipient or caregiver should contact the Medicaid DME Program when the need for the equipment no longer exists. The DME provider should not take back equipment from recipients or caregivers that were purchased by Medicaid. The provider should have the recipient or caregiver call the DME Program at 1-(800) 362-1504 when the equipment is no longer being used or needed.

14.3.2 Program Referrals

Refer to the Provider Manual's Appendix A, Well Child Checkup (EPSDT) for billing instructions regarding program referrals.

EPSDT 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 DME prescribed as a result of an EPSDT screening to treat or improve a defect, an illness, or a condition.

ACHN Referrals

When filing claims for recipients enrolled in the ACHN program, refer to Chapter 40, ACHN Billing Manual to determine whether your services require a referral from the PMP.

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 (Form 471: Prior Authorization Change Request) must be submitted to Medicaid's Medical and Quality Review contractor, prior to the expiration date indicated on the approval letter. Refer to Chapter 4, Obtaining Prior Authorization for information about the Form 471. 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.

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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. Native American Indians that present an "active user letter" issued by Indian health Services (IHS) will be exempt from the Medicaid required copayment.

The Medicaid DME Program requires copayment at the following rates:

Item	***Copay Amount***
Durable Medical Equipment, including crossovers	$3.90 for items costing $50.01 or more $2.60 for items costing $25.01-$50.00 $1.30 for items costing $10.01-$25.00
Supplies and Appliances, including crossovers	$3.90 for items costing $50.01 or more $2.60 for items costing $25.01-$50.00 $1.30 for items costing $10.01-$25.00 $0.65 for items costing $10.00 or less
Iron Infusion Pump Repair	$ 3.90 for each 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

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

DME providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When filing a claim on paper, a CMS-1500 claim form is required. Medicare-related claims must be filed on the Medical Medicaid/Medicare-related Claim Form.

Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

14.5.1 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.

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14.5.2 Diagnosis Codes

Effective June 1, 2008 DME providers may no longer bill using diagnosis code V729 on hard copy and electronically submitted claims. Providers will now be required to bill with specific diagnosis codes.

NOTE:

ICD-9 codes should be used for claims submitted with dates of service prior to or equal to 09/30/2015.

ICD-10 codes should be used for claims submitted with dates of service on/after 10/01/2015.

14.5.3 Procedure Codes and Modifiers

The medical supplies and appliances listed in Appendix P are available to eligible Medicaid recipients for use in their homes as prescribed by the prescriber and dispensed by a Medicaid contract provider.

For a complete listing of procedure codes and modifiers refer to Appendix P: Durable Medical Equipment (DME) Procedure Codes and Modifiers.

14.5.4 Place of Service Codes

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

POS	*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 CMS-1500 claim form must be submitted.

Refer to Section 5.8, 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
Obtaining Prior Authorization	Chapter 4
CMS-1500 Claim Filing Instructions	Chapter 5
Medical Necessity/Medically Necessary Care	Chapter 7
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N
DME Procedure Codes and Modifiers	Appendix P

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15 Eye Care Services

Medicaid pays for certain eye care services provided by participating Optometrists, Opticians, and Ophthalmologists.

Ophthalmologists may refer to Chapter 28, Physician, for additional information.

Medicaid also contracts with a Central Source contractor who is responsible for providing lenses and frames for Medicaid recipients. At the option of the provider taking the frame measurements, eyeglasses may be obtained from the Central Source or from any other source. Medicaid will pay no more than the contract price charged by the Central Source. Sample kits are available (frames and display containers) which can be purchased by eye care practitioners at the contractor's cost of frames plus mailing.

Effective September 1, 2023, the Central Source contractor is
Classic Optical Laboratories, Inc.
3710 Belmont Avenue
Youngstown, Ohio 44505
Phone: 1.888.522.2020
Website: www.classicoptical.com

Procedure Code prices through this Central Source Contract are effective for Dates of Service on or after September 1, 2023.

Please reference previous Provider Manual(s) for dates of service before September 1, 2023 and the price associated with procedure codes for lenses and frames.

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

15.1 Enrollment

Gainwell 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.

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

National Provider Identifier, Type, and Specialty

A provider who contracts with Medicaid as an Eye Care provider must enroll with their 10-digit National provider Identifier (NPI) that enables the provider to submit requests and receive reimbursements for eye care related claims.

A provider who contracts with Alabama Medicaid as an eye care provider is added to the Medicaid system with the NPI provided at the time application is made. Appropriate provider specialty codes are assigned to enable the provider to submit requests and receive reimbursements for eye care related claims. All nine digits are required when filing a claim.

Opticians are assigned a provider type of 19. Optometrists are assigned a provider type of 18. Valid specialties for Eye Care providers include the following:

Optician (190)

Optometrist (180)

Telemedicine (931) Ophthalmologist and Optometrist

Ophthalmologists are enrolled with a provider type of 31 (Physician). The valid specialty is Ophthalmologist (330).

Enrollment Policy for Eye Care Providers

To participate in Medicaid, eye care providers must have current certification and be licensed to practice in the state of Alabama, allowed by their licensing board and the laws of State of Alabama.

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

Off Site Mobile Physician's Services shall comply with all Medicaid rules and regulations as set forth in the State Plan, Alabama Medicaid Administrative Code, and Code of Federal Regulations including but not limited to the following requirements:

(a) Shall provide ongoing, follow-up, and treatment and/or care for identified conditions,

(b) Shall provide ongoing access to care and services through the maintenance of a geographically accessible office with regular operating business hours within the practicing county or within 15 miles of the county in which the service was rendered,

(c) Shall provide continuity and coordination of care for Medicaid recipients through reporting and communication with the Primary Medical Provider,

(d) Shall maintain a collaborative effort between the off-site mobile physician and local physicians and community resources. A matrix of

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responsibility shall be developed between the parties and available upon enrollment as an off-site mobile physician,

(e) Shall provide for attainable provider and recipient medical record retrieval,

(f) Shall maintain written agreements for referrals, coordinate needed services, obtain prior authorizations and necessary written referrals for services prescribed. All medical conditions identified shall be referred and coordinated.

- For additional information about ACHN please see Chapter 40.
- For additional information about EPSDT please see Appendix A.

(g) Shall not bill Medicaid for services which are offered to anyone for free. Provider shall utilize a Medicaid approved sliding fee scale based on Federal Poverty Guidelines,

(h) Shall ensure that medical record documentation supports the billing of Medicaid services, and

(i) Shall obtain signed and informed consent prior to treatment.

15.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations. Refer to Chapter 7, Understanding Your Rights and Responsibilities as a Provider, for general criteria on Medical Necessity/ Medically Necessary Care.

Refer to Chapter 112, Telemedicine Services, for general benefit information and limitations.

This section also discusses the types of eye examinations covered by Medicaid and describes the standards and procedures used to provide eyeglasses.

NOTE:

The Agency establishes annual benefit limits on certain covered services. Benefit limits related to eye care services are established every two calendar years for recipients 21 years of age or older. Therefore, it is imperative for Eye Care Providers/Contractors furnishing services to recipients 21 years of age and older, to verify benefit limits for three calendar years (last 2 and current year) to determine if the eye care benefit limits have been exhausted. Providers/Contractors who do not verify benefit limits for three calendar years (last 2 years and current year) for recipients 21 years of age and older risk a denial of reimbursement for those services. When the recipient has exhausted his or her benefit limit for a particular service, providers may bill the recipient.

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NOTE:

Prior authorized (PA) frames, lenses, exams, and fittings are now posting to the benefit limits screen. It is imperative to verify eligibility and benefit limits prior to rendering services. Please refer to Chapter 3, Verifying Recipient Eligibility for details.

15.2.1 Examinations

Medicaid eye care providers may administer and submit claims for several kinds of examinations, including the following:

- Examination for refractive error
- Optometrist services other than correction of refractive error
- Physician services

Providers may render services to Medicaid recipients confined to bed in a health care facility if the patient's attending physician documents that the patient is unable to leave the facility and that the examination is medically necessary

Examination for Refractive Error

Medicaid recipients 21 years of age and older are authorized one complete eye examination and work-up for refractive error every two calendar years. Recipients under 21 years of age are authorized the same service each calendar year or more often if medical necessity is documented through prior authorization. Please refer to Chapter 4 Obtaining Prior Authorization for more information.

Complete Eye Examinations

A complete eye examination and refractive error work-up includes the following services:

- Case history review
- Eye health examination
- Visual acuity testing
- Visual fields testing (if indicated)
- Tonometry
- Eyeglasses prescription (if indicated)
- Determining optical characteristics of lenses (refraction)

Examiners use the appropriate diagnosis code(s) to indicate the diagnosis.

NOTE:

For children, examination of eye tension and visual fields should be performed only if indicated.

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NOTE:

Procedure 92002 and 92012 **do not** count against the recipient's eye exam limits. However, these codes **will** count against the 14 annual physician office visit limit.

Please refer to Section 15.5.3 for additional information.

Optometrist Services

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

- During an eye examination, if the optometrist suspects or detects irregularities requiring medical treatment that is not allowed by state law to be provided by an optometrist, the optometrist refers the case to an appropriate doctor of medicine or osteopathy.
- Contact lenses (when medically necessary for anisometropia, keratoconus, aphakia, and high magnification difference between lenses) require prior authorization.
- Eyeglass lens changes, within lens specifications authorized by Medicaid, may be supplied when needed because of visual changes due to eye disease, surgery, or injury, require prior authorization.
- Orthoptics (eye exercises) require prior authorization.
- Photochromatic lenses require prior authorization.
- Post-operative cataract patients may be referred, with the patient's consent, to an optometrist for follow-up care as permitted by state law. Refer any subsequent abnormal or unusual conditions diagnosed during follow-up care back to the ophthalmologist.
- Artificial Eyes

NOTE:

All orders must be written according to practice guidelines and state/federal law and must include the date and signature of the provider, the service(s) ordered and the recipient's name.

Physician Services

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

- Contact lenses (when medically necessary for anisometropia, keratoconus, aphakia, and high magnification difference between lenses) require prior authorization.
- Orthoptics (eye exercises) require prior authorization.
- Eyeglass lens changes, within lens specifications authorized by Medicaid, may be supplied when needed because of visual changes due to eye disease, surgery, or injury, require prior authorization.
- Artificial Eyes

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15.2.2 Eyeglasses

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

Recipients 21 years of age and older are eligible for one pair of eyeglasses every two calendar years. Recipients under 21 years of age are authorized two pair of glasses each year if indicated by an examination, a prior authorization will be required for subsequent pairs requested in calendar year. These limitations also apply to fittings and adjustments.

Any exception to these benefit limits must be based on medical necessity and the reasons documented in the medical record. Examples of medical necessity could be for treatment of eye injury, disease, significant prescription change, or unrepairable damage to glasses. Additional eyeglasses cannot be authorized for convenience but only for clearly documented medically necessary reasons. An example for convenience may be more than one (1) pair of eyeglasses.

At the option of the provider taking the frame measurements, either the Central Source or any other source may provide eyeglasses that conform to Medicaid standards. Medicaid will pay no more than the contract price charged by the Central Source.

Frame Standards

See Section 15.5.3, Procedure Codes and Modifiers, for frame procedure codes and contract prices.

The authorized frames, or frames of equal quality, are provided for Medicaid recipients at the contract prices shown on the list. Under normal circumstances, the date of service for eyeglasses is the same as the date of examination. All frames must meet American National Standards Index (ANSI) standards.

Lens Standards

Lens specifications are authorized at the specified contract price. See Section 15.5.3, Procedure Codes and Modifiers, for lens procedure codes and contract prices.

Lenses are composed of clear glass, plastic or polycarbonate unless prior authorized by Medicaid because of unusual conditions. All lenses must meet Food and Drug Administration (FDA) impact-resistant regulations and conform to ANSI requirements.

Spherical lenses must have at least a plus or minus 0.50 diopter. The minimum initial correction for astigmatism only (no other error) is 0.50 diopter.

New Lenses Only

Patients who have old frames that meet the above standards may have new lenses installed instead of receiving new eyeglasses. Medicaid will pay for the lens only.

Include the following statement in the patient’s record: "I hereby certify that I used this patient's old frames and that I did not accept any remuneration therefore."

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New Frame Only

Patients who have old lenses that meet the above standards may have them installed in a new frame instead of receiving new eyeglasses.

Include the following statement on the patient's record: "I hereby certify that I used this patient's old lenses and that I did not accept any remuneration therefore."

Patient Requests Other Eyeglasses

If a patient chooses eyeglasses other than those provided by Medicaid, the patient must pay the complete cost of the eyeglasses, including fitting and adjusting; Medicaid will not pay any part of the charge. To prevent possible later misunderstanding, the provider should have the patient sign the following statement for the patient's record: "I hereby certify that I have been offered Medicaid eyeglasses but prefer to purchase the eyeglasses myself."

Additional Eye Exams or Eyeglasses for Recipients over 21 years of age

Medicaid may prior authorize additional eye exams and eyeglasses for recipients **over** 21 years of age only for medically necessary reasons such as eye injury, disease, unrepairable damage to glasses, or significant prescription change. The provider should forward an electronic PA request or an Alabama Prior Review and Authorization Request (Form 342) with a letter justifying necessity to Gainwell prior to ordering the eyeglasses.

Additional Eye Exams or Eyeglasses for Recipients under 21 years of age

Medicaid may prior authorize additional eye exams and eyeglasses for recipients **under** 21 years of age for medically necessary reasons such as eye injury, disease, unrepairable damage to glasses, or significant prescription change. Remember patients less than 21 years of age are authorized two pair of glasses each year if indicated by an examination. A prior authorization will be required for subsequent pairs requested in calendar year.

If this is a recent (within the last six months or less) replacement and does not necessitate another eye exam, you are not required to perform another eye exam.

Replacement of Eyeglasses due to Warranty or Workmanship

If the replacement request is necessary due to warranty or workmanship reasons and it is within 90 days of the original issue of the eyeglasses, contact your eyeglass fabricating provider for replacement of the eyeglasses at no cost.

Ordering Frames, Lenses and Eyeglasses

As provided in Section 15.2.2 above, providers may order eyeglasses from the Central Source, Classic Optical Laboratories, Inc., or any other source that conforms to Medicaid standards. When the Central Source provides eyeglasses, the provider cannot bill Medicaid for lenses and frames. Only the Central Source may submit claims for these services.

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15.3 Prior Authorization and Referral Requirements

The Medicaid program requires that Medicaid give authorization prior to the delivery or payment of certain eye care services. Refer to Chapter 4, Obtaining Prior Authorization, for information about requesting prior authorization.

Prior authorization from Medicaid is required for the following eye care services:

- Lens and frame change in same benefit period
- Orthoptic training (eye exercises)
- Additional comprehensive exams in same benefit period
- Photochromatic lenses
- Low vision aids
- Contact lenses (for anisometropia, keratoconus, aphakia, and high magnification difference between lenses)
- Progressive Lenses

All requests for prior authorization should include the following information:

1. Recipient's name
2. Recipient's Medicaid Number (thirteen-digits)
3. If the PA is requested due to a prescription change, past and current prescription data (complete for both eyes), including diagnosis code(s), is required
4. Exception requested (what is being requested)
5. Reason for exception (explain, e.g., cataract surgery date, etc…), with current justification
6. Signature of practitioner
7. Address of practitioner

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

Other Situations

Providers may render special services for unusual situations upon prior authorization. Medicaid must receive full, written information justifying medical necessity prior to the service being rendered. Please refer to Chapter 4, Obtaining Prior Authorization for more information.

ACHN PCP Referral Requirements

Refer to Chapter 40, ACHN, for information on ACHN requirements.

Eyeglass Contractors

If the Central Source provides eyeglasses, send them a copy of the approval letter from Medicaid bearing the prior authorization number.

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15.4 Cost Sharing (Copayment)

The copayment amount for office visit* including crossovers is:

$3.90 for procedure codes reimbursed $50.01 and greater
$2.60 for procedure codes reimbursed between $25.01 and $50.00
$1.30 for procedure codes reimbursed between $10.01 and $25.00

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

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

If one of these CPT codes is applicable for your practice, then copay applies.

Copayment does not apply to services provided for pregnant women, nursing facility residents, recipients less than 18 years of age, emergencies, and family planning. Native American Indians that present an "active user letter" issued by Indian Health Services (IHS) will be exempt from the Medicaid required copayment.

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

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15.5 Completing a Claim

To enhance the effectiveness and efficiency of Medicaid processing, provider should bill Medicaid claims electronically.

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

This section explains how to file claims for the following situations:

- Routine Checkups and Medicare
- 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

NOTE:

Providers who furnish services should only bill for those services provided. Please be aware when filing claims that the claim reflects services actually rendered/provided. Billing for services not provided could be considered fraudulent. Please ensure your billing staff is aware of appropriate billing practices.

Routine Checkups and Medicare

Medicare covers eye care services for medical eye conditions (i.e. glaucoma, cataracts, diabetes, etc.). For dual eligibles (recipients with Medicare and Medicaid), Medicaid is the payer of last resort. For medical eye conditions, Medicare should be billed first for consideration of payment. Upon Medicare payment, the crossover form and information should be forwarded to Gainwell for consideration of Medicaid payment. Should Medicare deny payment for a medical eye condition, seek all corrective Medicare remedies to ensure payment.

Medicare does not cover routine “Examination of Eyes and Vision” for a non-medical reason. When non-medical and routine “Examination of Eyes and Vision” services are denied by Medicare, claims should be sent to the Medical Support unit at the Alabama Medicaid Agency within 120 days of the Medicare EOMB date. The claim must have Medicare denial attached. These claims require manual review for appropriateness and will be overridden when indicated.

Eye Examination Only

When the Medicaid recipient undergoes an eye examination only, the examiner completes a claim that specifies "Complete Eye Examinations and Refraction."

If services other than a "complete examination" are provided, the claim should reflect the appropriate optometric procedure code or office visit code. Refer to

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

Eye Examination and Fitting by One Provider, Eyeglasses from the Central Source Contractor

Use the following procedure when one provider performs an eye examination (including refraction) and fitting (including frame service, verification, and subsequent service) and the Central Source contractor provides the eyeglasses.

1. The examiner completes the CMS-1500 claim form, separately identifying the examination, refraction, and fitting. The examiner does not bill lenses and frames.
2. The examiner forwards the Medicaid job order form reflecting all necessary prescription data, including frame required, to the Central Source.
3. The contractor fills the prescription and returns the eyeglasses to the examiner for delivery to the patient. The Patient or Authorized Signature box must be complete with the appropriate signature or the statement "Signature on file."
4. The Central Source contractor submits claims for payment to Gainwell.

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 Gainwell. 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 Gainwell.

Post-Operative Care

Medicaid will not process post-operative management claims until the referring ophthalmologist has received payment for surgery. The surgeon must first submit a modifier 54 with the appropriate surgical code. The optometrist should then submit a modifier 55 with the appropriate surgical code after the ophthalmologist has been paid in order to be paid for post-operative care.

Medicaid will deny post-operative claims when the surgeon (ophthalmologist) receives payment for the global amount. It is the responsibility of the optometrist to confer with the surgeon for appropriate claim corrections and/or submissions. The date of service for post-operative care cannot be greater than 7 days after the global surgical procedure. For example, if the surgery was performed on 12/01, then the follow up must be performed on or before 12/8.

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15.5.1 Time Limit for Filing Claims

Medicaid requires all claims to be filed within one year of the date of service. Refer to Section 5.1.5, Filing Limits, for more information regarding timely filing limits and exceptions.

15.5.2 Diagnosis Codes

The *International Classification of Diseases – 10th Revision - Clinical Modification* (ICD-10-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the
American Medical Association, AMA Plaza 330 North Wabash Ave, Suite 39300 Chicago, IL 60611-5885, or 1-800-621-8335.

NOTE:

ICD-9 codes should be used for claims submitted with dates of service prior to or equal to 09/30/2015.

ICD-10 codes should be used for claims submitted with dates of service on/after 10/01/2015.

NOTE:

ICD-9 or ICD-10 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

15.5.3 Procedure Codes and Modifiers

Medicaid uses the Healthcare Common Procedure Coding System (HCPCS). HCPCS is composed of the following:

- American Medical Association's Current Procedural Terminology (CPT)
- Nationally assigned codes developed by Medicare

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

This section lists procedure codes for optometric services and equipment arranged by type of service or equipment:

- Common Optometric services
- Special Optometric services
- Contact lenses
- Eyeglasses codes

Services requiring prior authorization are identified in the Prior Authorization column (PA required).

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To report intermediate, comprehensive, and special services, use the specific ophthalmological description.

Common Optometric Services

The Optometric Services listed below are those commonly used by Optometrists and Ophthalmologists. Procedure codes 92004 and 92014 should include a complete eye exam and work-up as outlined in Section 15.2.1.

Procedure Code	*Description*
92002	Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; intermediate, new patient
92004	Comprehensive, new patient, one or more visits
92012	Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient
92014	Comprehensive, established patient, one or more visits
92015	Determination of refractive state
99202	New Patient: Office or other outpatient visit for the management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter
99203	New Patient: Office or other outpatient visit for the management of a new patient, which requires a medically appropriate history and/or examination and low-level medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter
99204	New Patient: Office or other outpatient visit for the management of a new patient, which requires a medically appropriate history and/or examination and moderate-level medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.
99205	New Patient: Office or other outpatient visit for the management of a new patient, which requires a medically appropriate history and/or examination and high-level medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.
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 or other qualified health care professional. Usually the presenting problems are minimal.
99212	Established Patient: Office or other outpatient visit for the management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter.
99213	Established Patient: Office or other outpatient visit for the management of a new patient, which requires a medically appropriate history and/or examination and low-level medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter

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Procedure Code	*Description*
99214	Established Patient: Office or other outpatient visit for the management of a new patient, which requires a medically appropriate history and/or examination and moderate-level medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.
99215	Established Patient: Office or other outpatient visit for the management of a new patient, which requires a medically appropriate history and/or examination and moderate-level medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter.

Miscellaneous Procedures

Procedure Code	*Description*
99241	Office consultation for a new or established patient, which requires these three key components: • A problem focused history • A problem focused examination • Straightforward medical decision making
99242	Office consultation for a new or established patient, which requires these three key components: • An expanded problem focused history • An expanded problem focused examination • Straightforward medical decision making
99251	Inpatient consultation for a new or established patient, which requires these three key components: • A problem focused history • A problem focused examination • Straightforward medical decision making
99252	Inpatient consultation for a new or established patient, which requires these three key components: • An expanded problem focused history • An expanded problem focused examination • Straightforward medical decision making

Special Optometric Services

Procedure Code	*Description*	*PA Required*
92018	Opthalmological examination and evaluation under general anesthesia, with or without manipulation of globe for passive range of motion or other manipulation to facilitate diagnostic evaluation	No
92019	Limited	No
92020	Gonioscopy (separate procedure)	No
92060	Sensorimotor examination with multiple measurements of ocular deviation (e.g., restrictive or paretic muscle with diplopia) with interpretation and report (separate procedure)	No
92065	Orthoptic training and/or pleoptic training, with continuing medical direction and evaluation (requires prior authorization from Medicaid)	Yes
92071	Fitting of contact lenses for treatment of ocular surface disease	No

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Procedure Code	*Description*	*PA Required*
92072	Fitting of contact lenses for management of keratoconus, initial fitting	No
92081	Visual field examination, unilateral or bilateral, with interpretation and report; limited examination (eg, tangent screen, Autoplot, arc perimeter, or single stimulus level automated test, such as Octopus 3 or 7 equivalent) For children: examination of eye tension and visual fields should be performed only if indicated.	No
92082	Intermediate examination (eg, at least 2 isopters on Goldmann perimeter, or semiquantitative, automated suprathreshold screening program, Humphrey suprathreshold automatic diagnostic test, Octopus program 33)	No
92083	Extended examination (eg, Goldmann visual fields with at least 3 isopters plotted and static determination within the central 300	No
92100	Serial tonometry (separate procedure) with multiple measurements of intraocular pressure over an extended time period with interpretation and report, same day (eg, diurnal curve or medical treatment of acute elevation of intraocular pressure)	No
92136	Opthalmic biometry by partial coherence interferometry with intraocular lens power calculation	No
92140	Provocative tests for glaucoma, with interpretation and report, without tonography	No
92230	Florescein angioscopy with interpretation and report	No
92250	Fundus photography with interpretation and report	No
92260	Opthalmolodynamometry	No
92270	Electro-oculography with interpretation and report	No
92275	Electroretinography with interpretation and report	No
92283	Color vision examination extended, e.g., anomaloscope or equivalent	No
92284	Dark adaptation examination with interpretation and report	No
92285	External ocular photography with interpretation and report for documentation of medical progress (eg, close-up photography, slit lamp photography, goniophotography, stereo-photography)	No
92340	Fitting of spectacles, except aphakia; monofocal	No
92341	Bifocal	No
92342	Multifocal, other than bifocal	No
92352	Fitting of spectacle prosthesis for aphakia; Monofocal	No
92353	Multifocal	No
92354	Fitting of spectacle mounted low vision aid; single element system	No
92355	Telescopic or other compound lens system	No
92358	Prosthesis service for aphakia, temporary (disposable or loan, including materials)	No
92370	Repair and refitting spectacles; except for aphakia	No
92371	Spectacle prosthesis for aphakia	No

Surgical Procedures

Procedure Code	*Description*
65205*	Removal of foreign body, external eye; conjunctival superficial

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Procedure Code	*Description*
65210*	Conjunctival embedded (includes concretions), subconjunctival, or scleral nonperforating
65220*	Corneal, without slit lamp
65222*	Corneal, with slit lamp
68801*	Dilation of lacrimal punctum, with or without irrigation
68810*	Probing of nasolacrimal duct, with or without irrigation

* Service Includes Surgical Procedure Only

Post-Operative Care Modifiers

Use the appropriate modifier identifying post-operative management when submitting claims.

1st Modifier	*Description*
55	Postoperative Management (Optometrist)
54	Surgical Care (Opthamologist)
2nd Modifier	***Description***
RT	Right Eye
LT	Left Eye

Contact Lenses

Contact lenses may be provided for post-cataract surgery, anisometropia, keratoconus treatment, and high magnification difference between lenses. Fitting services are billed as a separate billed item. Lenses are billed per lens. Prior authorization is required for lenses and fitting services.

Procedure Code	*Modifier, If Applicable*	*Description*	*PA Required*
V2501		Contact lens, PMMA, toric or prism ballast	Yes
V2502		Contact lens, PMMA, bifocal	Yes
V2503		Contact lens, PMMA, color vision deficiency	Yes
V2510		Contact lens, gas permeable, spherical	Yes
V2511		Contact lens, gas permeable, toric	Yes
V2512		Contact lens, gas permeable, bifocal, per lens	Yes
V2513		Contact lens, gas permeable, extended wear	Yes
V2520		Contact lens, hydrophilic, spherical	Yes
V2521		Contact lens, hydrophilic, toric	Yes
V2522		Contact lens, hydrophilic, bifocal	Yes
V2523		Contact lens, hydrophilic, extended wear	Yes
V2530		Contact lens, sclera, gas impermeable	Yes
V2531		Contact lens, gas permeable	Yes
V2599		Contact lens, other type	Yes
92310	52	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens, both eyes, except for aphakia	Yes
92311		Corneal lens for aphakia, one eye	Yes
92312		Corneal lens for aphakia, both eyes	Yes
92313		Corneoscleral lens	Yes

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Procedure Code	*Modifier, If Applicable*	*Description*	*PA Required*
V2501		Contact lens, PMMA, toric or prism ballast	Yes
V2502		Contact lens, PMMA, bifocal	Yes
V2503		Contact lens, PMMA, color vision deficiency	Yes
92314		Prescription of optical and physical characteristics of contact lens, with medical supervision of adaptation and direction of fitting by independent technician; corneal lens, both eyes except for aphakia	Yes
92315		Corneal lens for aphakia, one eye	Yes
92316		Corneal lens for aphakia, both eyes	Yes
92317		Corneoscleral lens	Yes
92325		Modification of contact lens (separate procedure), with medical supervision of adaptation	No
92326		Replacement of contact lens	Yes

Eyeglasses Codes

At the option of the provider making the frame measurements, eyeglasses that conform to Medicaid standards may be procured from either the Central Source or from any other source. However, Medicaid will pay only the contract price charged by the Central Source.

Use the procedure codes and prices listed below for lenses. Add-on lens treatments requiring prior authorization are listed separately.

The lens specifications below are authorized at the specified contract price. Lenses must meet FDA impact-resistant regulations and must be made of glass or clear plastic except when other materials are prior authorized by Medicaid for unusual conditions. Spherical lenses must be at least a plus or minus 0.50 diopter. The minimum initial correction for astigmatism only (with no other error) is 0.50 diopter.

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Pricing for New Eyeglass Contract-Classic Optical
Effective Date September 1, 2023

LENS SPECIFICATIONS: (CLEAR GLASS, CLEAR PLASTIC OR CLEAR POLYCARBONATE) PER LENS

Please reference section 15.3 for lenses requiring prior authorizations and/or add on costs as well as other eye care service details.

Procedure Code and Description	Price per lens
V2020 - VISION SVCS FRAMES PURCHASES	$ 19.50
+V2025 - EYEGLASSES DELUX FRAMES	$ 35.00
V2100 - LENS SPHER SINGLE PLANO 4.00	$ 9.99
V2101 - SINGLE VISN SPHERE 4.12-7.00	$ 9.99
V2102 - SINGL VISN SPHERE 7.12-20.00	$ 9.99
V2103 - SPHEROCYLINDR 4.00D/12-2.00D	$ 9.99
V2104 - SPHEROCYLINDR 4.00D/2.12-4D	$ 9.99
V2105 - SPHEROCYLINDER 4.00D/4.25-6D	$ 9.99
V2106 - SPHEROCYLINDER 4.00D/>6.00D	$ 9.99
V2107 - SPHEROCYLINDER 4.25D/12-2D	$ 9.99
V2108 - SPHEROCYLINDER 4.25D/2.12-4D	$ 9.99
V2109 - SPHEROCYLINDER 4.25D/4.25-6D	$ 9.99
V2110 - SPHEROCYLINDER 4.25D/OVER 6D	$ 9.99
V2111 - SPHEROCYLINDR 7.25D/.25-2.25	$ 9.99
V2112 - SPHEROCYLINDR 7.25D/2.25-4D	$ 9.99
V2113 - SPHEROCYLINDR 7.25D/4.25-6D	$ 9.99
V2114 - SPHEROCYLINDER OVER 12.00D	$ 9.99
V2115 - LENS LENTICULAR BIFOCAL	$ 9.99
V2118 - LENS ANISEIKONIC SINGLE	$ 9.99
V2121 - LENTICULAR LENS, SINGLE	$ 9.99
V2199 - LENS SINGLE VISION NOT OTH C	$ 35.00
V2200 - LENS SPHER BIFOC PLANO 4.00D	$ 14.00
V2201 - LENS SPHERE BIFOCAL 4.12-7.0	$ 14.00
V2202 - LENS SPHERE BIFOCAL 7.12-20.	$ 14.00
V2203 - LENS SPHCYL BIFOCAL 4.00D/.1	$ 14.00
V2204 - LENS SPHCY BIFOCAL 4.00D/2.1	$ 14.00
V2205 - LENS SPHCY BIFOCAL 4.00D/4.2	$ 14.00
V2206 - LENS SPHCY BIFOCAL 4.00D/OVE	$ 14.00
V2207 - LENS SPHCY BIFOCAL 4.25-7D/.	$ 14.00
V2208 - LENS SPHCY BIFOCAL 4.25-7/2.	$ 14.00

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V2209 - LENS SPHCY BIFOCAL 4.25-7/4.	$ 14.00
V2210 - LENS SPHCY BIFOCAL 4.25-7/OV	$ 14.00
V2211 - LENS SPHCY BIFO 7.25-12/.25-	$ 14.00
V2212 - LENS SPHCYL BIFO 7.25-12/2.2	$ 14.00
V2213 - LENS SPHCYL BIFO 7.25-12/4.2	$ 14.00
V2214 - LENS SPHCYL BIFOCAL OVER 12.	$ 14.00
V2215 - LENS LENTICULAR BIFOCAL	$ 14.00
V2218 - LENS ANISEIKONIC BIFOCAL	$ 14.00
V2219 - LENS BIFOCAL SEG WIDTH OVER	$ 14.00
V2220 - LENS BIFOCAL ADD OVER 3.25D	$ 14.00
V2221 - LENTICULAR LENS, BIFOCAL	$ 14.00
V2299 - LENS BIFOCAL SPECIALITY	$ 40.00
V2300 - LENS SPHERE TRIFOCAL 4.00D	$ 12.00
V2301 - LENS SPHERE TRIFOCAL 4.12-7.	$ 12.00
V2302 - LENS SPHERE TRIFOCAL 7.12-20	$ 12.00
V2303 - LENS SPHCY TRIFOCAL 4.0/.12-	$ 12.00
V2304 - LENS SPHCY TRIFOCAL 4.0/2.25	$ 12.00
V2305 - LENS SPHCY TRIFOCAL 4.0/4.25	$ 12.00
V2306 - LENS SPHCYL TRIFOCAL 4.00/>6	$ 12.00
V2307 - LENS SPHCY TRIFOCAL 4.25-7/.	$ 12.00
V2308 - LENS SPHC TRIFOCAL 4.25-7/2.	$ 12.00
V2309 - LENS SPHC TRIFOCAL 4.25-7/4.	$ 12.00
V2310 - LENS SPHC TRIFOCAL 4.25-7/>6	$ 12.00
V2311 - LENS SPHC TRIFO 7.25-12/.25-	$ 12.00
V2312 - LENS SPHC TRIFO 7.25-12/2.25	$ 12.00
V2313 - LENS SPHC TRIFO 7.25-12/4.25	$ 12.00
V2314 - LENS SPHCYL TRIFOCAL OVER 12	$ 12.00
V2315 - LENS LENTICULAR TRIFOCAL	$ 12.00
V2318 - LENS ANISEIKONIC TRIFOCAL	$ 12.00
V2319 - LENS TRIFOCAL SEG WIDTH > 28	$ 12.00
V2320 - LENS TRIFOCAL ADD OVER 3.25D	$ 12.00
V2321 - LENTICULAR LENS, TRIFOCAL	$ 12.00
V2399 - LENS TRIFOCAL SPECIALITY	$ 40.00
V2410 - LENS VARIAB ASPHERICITY SING	$ 12.00
V2430 - LENS VARIABLE ASPHERICITY BI	$ 25.00
V2499 - VARIABLE ASPHERICITY LENS	$ 35.00
*V2700 - BALANCE LENS	$ 0.25
*V2710 - GLASS/PLASTIC SLAB OFF PRISM	$ 1.00
V2715 - PRISM LENS/ES	$ 10.00

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*V2718 - FRESNELL PRISM PRESS-ON LENS	$ 5.00
*V2744 - TINT PHOTOCHROMATIC LENS/ES	$ 1.00
V2745 - TINT, ANY COLOR/SOLID/GRAD	$ 1.00
V2750 - ANTI-REFLECTIVE COATING	$ 5.00
V2755 - UV LENS/ES	$ 2.00
V2760 - SCRATCH RESISTANT COATING	$ 2.00
V2780 - OVERSIZE LENS/ES	$ 1.00
*V2781 - PROGRESSIVE LENS PER LENS	$ 5.00
V2782 - LENS, 1.54-1.65 P/1.60-1.79G	$ 5.00
V2783 - LENS, >= 1.66 P/>=1.80 G	$ 5.00
V2784 - LENS POLYCARB OR EQUAL	$ 0.01

+This is a frame utilized for those patients requiring a special/unusual size and/or shape frame (e.g., Miraflex, Specs4Us, and ANSI-rated safety frames).

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

NOTE:

Medical record documentation should support the medical appropriateness of billing procedures V2299 and/or V2399. These services are subject to post payment review.

Effective July 1, 2002, the locally assigned procedure codes for frames are converted to one of two codes (PC), V2020 and V2025.

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

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15.5.5 Required Attachments

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

- Claims With Third Party Denials

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

Refer to Section 5.8, Required Attachments, for more information on attachments.

15.6 For More Information

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

Resource	Where to Find it
CMS-1500 Claim Filing Instructions	Section 5.2
Medical Medicaid/Medicare-related Claim Filing Instructions	Section 5.7.1
Medical Necessity/Medically Necessary Care	Chapter 7
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N

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16 Federally Qualified Health Centers (FQHC)

A Federally Qualified Health Center (FQHC) is a health care center that meets one of the following requirements:

- Receives a grant under Section 329, 330, 340, or 340A of the Public Health Services Act
- Meets the requirements for receiving such a grant as determined by the Secretary based on the recommendations of the Health Resources and Services Administration within the Public Health Service
- Qualifies through waivers of the requirements described above as determined by the secretary for good cause
- Functions as outpatient health programs or facilities operated by a tribe or tribal organization under the Indian Self-determination Act

The policy provisions for FQHC providers can be found in the *Alabama Medicaid Agency Administrative Code,* Chapter 48.

16.1 Enrollment

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

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

National Provider Identifier, Type, and Specialty

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

Federal requirements mandate providers re-validate periodically with the Alabama Medicaid program. Providers will be notified when they are scheduled to re-validate. Failure to re-validate and provide appropriate documentation to complete enrollment will result in an end-date being placed on the provider file. Once a provider file has been closed for failure to timely re-validate, providers will have to submit a new application for enrollment. The 10-digit NPI is required when filing a claim.

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FQHC facilities are assigned a provider type of 56 (FQHC) and the valid specialty is 080 (Federally Qualified Health Center). Registered nurses should bill using the clinic number as the rendering NPI (Block 24J) on the CMS-1500 claim form.

Physicians, Nurse Midwives, Certified Registered Nurse Practitioners, and Physician Assistants affiliated with the FQHC are issued individual NPIs that are linked to the FQHC number. Each of these providers is assigned a provider type of 56 (FQHC). Valid specialties are as follows:

- All valid specialties associated with physicians (refer to Chapter 28 Physician)
- 095 (Certified Nurse Midwife)
- 093 (Certified Registered Nurse Practitioner)
- 100 (Physician Assistant)
- 074 (Licensed Independent Clinical Social Worker) LICSW

Enrollment Policy for FQHC Providers

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

- Submit appropriate documentation from the Department of Health Resources and Services, Public Health Services (PHS), that the center meets FQHC requirements as evidenced by a copy of a grant awards letter
- Submit a budgeted cost report for its initial cost reporting period
- Federally Funded Health Centers, which are Medicare certified, must also submit copies of Medicare certification
- Comply with the Clinical Laboratory Improvement Amendments of 1988 (CLIA) for all laboratory-testing sites
- Each satellite center must complete an enrollment application. Physicians, Nurse Practitioners, Nurse Midwives, Physician Assistants, Psychologists, and Licensed Independent Clinical Social Workers associated with the clinic must also complete enrollment applications.

Provider contracts are valid for the time of the grant award period, and are renewed yearly in accordance with the grant renewal by PHS. A copy of the grant renewal by PHS must be forwarded to Medicaid as verification of continuing FQHC status. They are renewed upon receipt of proof that requirements stated in the *Alabama Medicaid Agency Administrative Code* Rule No. 560-X-48-01 have been met.

The effective date of enrollment will be the first day of the month in which the Medicaid enrollment application was received and the termination date will be 60 days beyond the end date of the budget period on the Grant Award Notice.

FQHCs approved for enrollment will be issued a provider agreement for the services for which they agree to provide. This agreement must be signed and returned to Medicaid within 30 days of the date mailed to the provider. Names of satellite center(s) are indicated in the provider agreement.

Mobile Dental Clinic

- Complete guidelines for mobile dental clinics are in Provider Manual Chapter 13 Dental.

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FQHCs are required to notify Medicaid's fiscal agent 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

Alabama Coordinated Health Network (ACHN) Requirements for Federally Qualified Health Centers (FQHC)

- Refer to Chapter 40 for details and requirements about the ACHN Program.

Change of Ownership (CHOW) and Closures

Medicaid will mirror Medicare's Change of Ownership (CHOW) policy. Refer to Chapter 19, Hospital for additional information on Change of Ownership

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. Refer to Chapter 7, Understanding Your Rights and Responsibilities as a Provider, for general criteria on Medical Necessity/ Medically Necessary Care. Refer to Chapter 28, Physician, for additional information for FQHC physicians, Nurse Practitioners, Nurse Midwives, and Physician Assistants.

Mental Health

- Psychologists and Licensed Independent Clinical Social Workers may provide services to EPSDT/QMB referred recipients. Please refer to Provider Manual Chapter 34 Behavioral Health for additional information.

16.2.1 Benefits

Services provided by an FQHC include medically necessary diagnostic and therapeutic services and supplies provided by a physician, physician assistant, nurse midwife, nurse practitioner, clinical psychologist, registered nurses, or clinical social worker; and services and supplies incidental to such services as would otherwise be covered if furnished by a physician. Any other ambulatory services offered by the center that are included in the State Plan are covered except for home health. Home Health services are excluded as an FQHC service because home health services are available on a state wide basis.

The CRNP can make physician-required visits to nursing facilities. However, a CRNP cannot make physician required inpatient visits to hospitals or other institutional settings to qualify for payment to the physician or to satisfy

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current regulations as physician visits. The PA or CRNP may provide low complexity or straightforward medical decision-making services in the emergency department or assist at surgery (identified surgical codes only) for Medicaid reimbursement.

16.2.2 Limitations

Home health services are excluded as an FQHC service because home health services are available on a statewide basis.

Reimbursement for other ambulatory services covered by the State Plan includes but is not limited to Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) for individuals under age 21, family planning, prenatal, and dental for individuals under age 21. These services are subject to policies and routine benefit limitations for the respective program areas. These services do not count against the routine benefit limits for medical encounters.

FQHC clinic visits, outpatient, and inpatient services are subject to the same routine benefit limitations as physician visits. Refer to the *Alabama Medicaid Agency Administrative Code,* Chapter 6, for details.

16.2.3 Reimbursement

As described in Section 1902(aa) of the Social Security Act, FQHCs will be paid under a prospective payment system rate (PPS rate) effective January 1, 2001. The rate setting period is from October 1 through September 30th. Each FQHC is entitled to the payment amount (on a per visit basis) to which the FQHC was entitled to in the previous fiscal year, increased by the percentage increase in the Medicare Economic Index (MEI) for primary care services, and adjusted to take into account any increase (or decrease) in the scope of services furnished by the FQHC during that fiscal year.

If a service has been eliminated, the Health Center must notify Medicaid that they have discontinued a given service. Medicaid must be notified in writing within ninety (90) calendar days of any termination of service(s). The notification of discontinued service must include the 12-month cost report for the discontinued service leading up to the termination of the service. The Agency may request additional documentation. An elimination of a service or services will not result in a rate adjustment unless the elimination has a cost impact of 3%. Failure to notify Medicaid of a termination of service may result in recoupment of paid claims.

Deleted: ~~This decrease in…the PPS rate.~~
Added: An elimination of…impact of 3%.

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.

Deleted:~~NOTE: A deletion…CIS submission limitation.~~

Reimbursement for all new FQHC providers or providers who have a Medicaid approved change in scope will be subject to the ceiling provided under rule 560-X-56.04(3)

Deleted: ~~Reimbursement for all…rule 560-X-56.04(3)~~

Change in Scope (CIS)

Deleted: ~~Ceiling The new…in-state facilities.~~

An FQHC may request that their PPS rate be adjusted to take into account a change (either increase or decrease) in the scope of services furnished by the FQHC. A change in scope of services is defined as a change in the type, intensity, duration, and/or amount of services provided during a FQHC visit.

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Change in Scope requests must meet regulatory compliance as required by state and federal law as it relates to the operation of FQHC services provided under the Alabama Medicaid ("Medicaid") Program.

A change in scope request must be sent to the Managed Care Operations Division for review. The request must specifically state what FQHC service was changed, and specifically detail how the type, intensity, duration, or amount of that service has changed. Medicaid will not review the CIS request until a complete submission is received. A complete submission includes the documentation listed below. The CIS request must be submitted to the Agency no later than 180 days (six months) after the Health Clinic's fiscal year end. The request shall include, at a minimum, the following clearly labeled and identified documentation:

1. Narrative of the Qualifying Event or Events including a description of the Event or Events and other relevant information such as the locations affected, the date new services began, time period over which the changes took place or how patients are impacted; any relevant supporting documentation should also be provided. The Health Clinic must specify their fiscal year period in the narrative that will be submitted with the CIS request. Failure to disclose the fiscal year in the narrative will result in an incomplete submission.
2. A current copy of Form 5A, 5B, and 5C, if applicable.
3. A current copy of HRSA's Notice of Award (NOA), if applicable.
4. A CIS Medicaid cost report with at least 12-months of actual expenses associated with the requested change in scope.
   - The Medicaid cost report must reflect ALL clinic visits. Also, initial supporting documentation must include the following:
     - General Ledger Detail (in excel format) for the period under audit
     - Trial Balance (in excel format)
     - Crosswalk of Trial Balance accounts to Medicaid cost report line item
     - Medicare Cost Report for period(s) consistent with the Medicaid Cost Report
5. The FQHC's proposed PPS rate with detailed documentation of how the proposed PPS rate was derived or calculated.
6. A listing of deleted services not reported to Medicaid, if applicable. Listing must include the deleted service and the date the service was deleted.
7. The current HRSA UDS Report (detailed) that contains the change in scope qualifying events.

The Medicaid Agency may request more documentation or clarification of the documentation provided. If the FQHC fails or refuses to provide the documentation requested by the Medicaid Agency, the change in scope request may be denied. FQHCs may submit one CIS request within 12-months of the last submitted CIS request.

Added: Medicaid will not…documentation listed below.
Deleted: ~~should~~
Added: must
Deleted: ~~ninety (90)~~
Added: 180
Added: (six months)
Deleted: ~~twelve (12) months of CIS activity~~
Added: the Health Clinic's fiscal year end.
Added: clearly labeled and identified.
Added: The Health Clinic…an incomplete submission.
Added: Medicare Cost Report…Medicaid Cost Report
Deleted: ~~Other documentation as…by the Agency.~~
Deleted: ~~FQHCs shall only…state fiscal year.~~
Added: FQHCs may submit…submitted CIS request.

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Added: NOTE: A deletion…scope rate adjustment.

NOTE:

A deletion in service(s) does not count towards the 12-month CIS submission limitation.

The Agency will notify the Health Clinic within seven days of receipt of a CIS request. If the Health Clinic does not receive a response within seven days, it is the Health Clinic's responsibility to reach out to the Agency regarding receipt of the CIS request. The Agency will review the CIS request to determine if the CIS request is complete. The Agency will notify the Health Clinic within 30 days regarding the completion status of the CIS request. The Agency will notify the Health Clinic within 60 days from CIS submission completion date of the approved qualifying events.

A change in the scope of service occurs if the FQHC has added or discontinued any service that meets the definition of FQHC services as provided in Section 1905(a) (2) (B) and (C) of the Act, and the service is included as a covered Medicaid service under the Alabama Medicaid State Plan. A change in the scope of service is defined as a change in the type, intensity, duration and/or amount of services compared to the services offered at the time of the last change of scope rate adjustment.

Deleted: ~~The change in…amount, or duration.~~

Added: Type- the FQHC/RHC…to changing circumstances.

Type- the FQHC/RHC has added or dropped any service that meets the definition of FQHC/RHC services as provided in section 1905(a) (2) (B) and (C) of the Social Security Act or if the service is included as a covered Medicaid service in the State Plan.

Intensity- a change in the characteristics of services offered in an average visit such that the average patient receives a different array of services.

Amount- an increase or decrease in the quantity of services that an average patient receives in an average visit.

Duration- a change in the average length of time it takes medical providers to complete an average patient visit due to changing circumstances.

A change in scope review will not take increased costs or inflation into account. Further, Patient-Centered Medical Home (PCMH) certification will not qualify for a rate adjustment. When the cost of the changed service has been determined, the incremental/decremental rate adjustment to the individual service will be combined into the overall PPS rate thereby calculating a revised encounter rate. Only the services that changed will be included in the PPS rate calculation during the change in scope request review. If the new PPS rate results in an overall increase or decrease of at least 3 percent of the PPS rate at the time Medicaid receives the change in scope request, then the PPS rate will be adjusted. The effective date of the new PPS rate will be the first day of the month that the Medicaid Agency receives a completed CIS request. The Agency will notify the health clinic within 30 days if the CIS request is complete or not. A complete submission includes the documentation listed above.

Deleted: ~~The new PPS…final rate determination.~~
Added: The effective date…documentation listed above

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Added: NOTE: For example…be May 1st.

NOTE:

For example: if a CIS request is received on March 31, but does not contain all required information, it will be returned. On May 15th, the Agency receives the resubmitted CIS request with all required documentation, therefore the effective date will be May 1st.

The FQHC must demonstrate the following:

- a cost impact per qualifying event or a combination of more than one qualifying event and
- the incremental cost impact per visit to the change in scope of service.

Any costs supporting the rate adjustment must be allowable for FQHCs under the Administrative Code Chapter 56- Federally Qualified Health Center Reimbursement. The calculated incremental cost per visit of the change in scope will be applied to the PPS rate currently in effect.

A Change in Scope request may take more than a period of one year to process; however, the Agency anticipates processing change in scope requests within 6 months. For additional information, please contact the Managed Care Operations Division.

NOTE:

New PPS rates due to an approved change in scope will be based on the incremental and/or decremental costs of the approved qualifying event(s).

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
- Prescription drugs by enrolled pharmacy providers
- Surgical procedures performed in place of service 21 (inpatient) or 22 (outpatient) will be reimbursed fee-for-service

Family Planning

- Family planning services are services provided to prevent or delay pregnancy.
- The Plan First visit will be reimbursed at the encounter rate when billed.
- Complete guidelines for family planning are in the Provider Billing Manual, Appendix C.

1st Look- The Oral Health Risk Assessment and Dental Varnishing Program

For additional Oral Health Risk Assessment and Dental Varnishing information and guidelines please refer to Medicaid's Provider Manual's Dental Chapter 13.

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16.2.4 Encounters

Encounters are face-to-face contacts between a patient and a health professional for medically necessary services. A patient may have one physical health encounter and one behavioral health (psychologist or clinical social worker) encounter on the same day. If the patient later suffers an illness or injury requiring additional diagnosis or treatment on the same date of service, a separate encounter may be billed.

Dental services are limited to one dental encounter per date of service. A patient can have one dental encounter in addition to one physical health and/or behavioral health 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 Medicaid's fiscal agent 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 Medicaid's fiscal agent 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 ACHN program, refer to Chapter 40 to determine whether your services require a referral from the Primary Care Physician (PCP).

16.4 Cost Sharing (Copayment)

The copayment amount is **$3.90** per visit including crossovers. Copayment does not apply to services provided for pregnant women, nursing facility residents, recipients less than 18 years of age, emergencies, and family planning. Native American Indians that present an "active user letter" issued by Indian health Services (IHS) will be exempt from the Medicaid required copayment.

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

16.5 Medicare Co-insurance

For Federally Qualified Health Centers, Medicaid pays the Medicare co-insurance up to the encounter rate established by Medicaid.

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16.6 Completing a Claim

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

- Physicians, Certified Registered Nurse Practitioners, and Physician Assistants bill using their own NPI on Block 24J of the CMS-1500 claim form. Enter the clinic's number in Block 33 in the GRP # portion of the field. Please refer to Section 5.2.2, CMS-1500 Claim Filing Instructions, for more information.

16.6.1 Diagnosis Codes

The *International Classification of Diseases - 10th Revision - Clinical Modification* (ICD-10-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, AMA Plaza 330 North Wabash Ave, Suite 39300 Chicago, IL 60611-5885, or 1-800-621-8335.

NOTE:

ICD-9 codes should be used for claims submitted with dates of service prior to or equal to 09/30/2015.

ICD-10 codes should be used for claims submitted with dates of services on/after 10/01/2015.

NOTE:

ICD-9 or ICD-10 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

16.6.2 Procedure Codes and Modifiers

Medicaid uses the Healthcare Common Procedure Coding System (HCPCS). HCPCS is composed of the following:

- American Medical Association's Current Procedural Terminology (CPT)
- Nationally assigned codes developed for Medicare
- Locally assigned codes issued by Medicaid. Effective for dates of service on or after 01/01/2004, use national codes.

The CPT manual lists most procedure codes required by Medicaid. This manual may be obtained by contacting the Order Department, American Medical Association, 515 North State Street, Chicago, IL 60610-9986.

Refer to Appendix H, Alabama Medicaid Injectable Drug Listing.

Claims without procedure codes or with codes that are invalid will be denied. Medicaid recognizes modifiers when applicable. Both CPT and CMS level codes will be recognized. The (837) Professional, Institutional and Dental electronic claims and the paper claims have been modified to accept up to four Procedure Code Modifiers.

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Collection of laboratory specimens may be billed only when sending specimens to another site for analysis if the other site is not owned, operated, or financially associated with the site in which the specimen was collected.

The collection fee may not be billed if the lab work is done at the same site where the specimen was collected or in a lab owned, operated, or financially associated with the site in which the specimen was collected.

Providers will not be paid for and should not submit claims for laboratory work done for them by independent laboratories or by hospital laboratories.

Providers may submit claims for laboratory work done by them in their own offices or own laboratory facilities. Providers who send specimens to independent laboratories for analysis may bill a collection fee. This fee shall not be paid to any provider who has not actually extracted the specimen from the patient.

NOTE:

Providers should use procedure code 36415-90 for routine venipuncture collection, 36416-90 for collection of capillary blood specimen (eg, finger, heel, ear stick) and Q0091-90 for collection of Pap smear specimen.

Nurse Practitioners/Physician Assistants

Covered services for FQHC-employed nurse practitioners and physician assistants are limited to the following:

- Laboratory codes for which the clinic is certified to perform
- CPT codes as specified in Chapter 21, CRNP and PA Services

Effective January 1, 1998, services provided by Registered Nurses (RNs) employed in a FQHC will be reimbursed only under the FQHC site name and number. Reimbursable services provided by an RN in an FQHC are restricted to the following:

Procedure Codes	***Description***
99205-FP	Family Planning, initial visit
99214-FP	Family Planning, annual visit
99213-FP	Family Planning, periodic revisit
99212-FP	Family Planning, expanded counseling visit
99401	Family Planning, HIV pre-test counseling
99402	Family Planning, HIV post-test counseling
99381-EP	Initial EPSDT, Normal, under 1 year of age
99382-EP	Initial EPSDT, Normal, 1-4 years of age
99383-EP	Initial EPSDT, Normal, 5-11 years of age
99384-EP	Initial EPSDT, Normal, 12-17 years of age
99385-EP	Initial EPSDT, Normal, 18-20 years of age
99381-EP	Initial EPSDT, abnormal, under 1 year of age
99382-EP	Initial EPSDT, abnormal, 1-4 years of age
99383-EP	Initial EPSDT, abnormal, 5-11 years of age
99384-EP	Initial EPSDT, abnormal, 12-17 years of age
99385-EP	Initial EPSDT, abnormal, 18-20 years of age
99381-EP	Periodic EPSDT, normal, under 1 year of age
99382-EP	Periodic EPSDT, normal, 1-4 years of age
99383-EP	Periodic EPSDT, normal, 5-11 years of age
99384-EP	Periodic EPSDT, normal, 12-17 years of age

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Procedure Codes	*Description*
99385-EP	Periodic EPSDT, normal, 18-20 years of age
99381-EP 99382-EP 99383-EP 99384-EP 99385-EP	Periodic EPSDT, abnormal, under 1 year of age Periodic EPSDT, abnormal, 1-4 years of age Periodic EPSDT, abnormal, 5-11 years of age Periodic EPSDT, abnormal, 12-17 years of age Periodic EPSDT, abnormal, 18-20 years of age
*99391	Interperiodic Screening, Infant age- below 1 year old
*99392	Interperiodic Screening, Early Childhood-age 1 thru 4 years
*99393	Interperiodic Screening, Late Childhood-age 5 thru 11 years
*99394	Interperiodic Screening, Adolescent-age 12 thru 17 years
*99395	Interperiodic Screening-age 18 thru 20 years
99173-EP	EPSDT Vision Screen
92551-EP	EPSDT Hearing Screen

* Must be approved by the Alabama Medicaid Agency to provide these services.

Vaccines For Children (VFC)

Refer to Appendix A, EPSDT, for additional information.

Injectable drug codes, as specified in Appendix H, Alabama Medicaid Injectable Drug List.

16.6.3 Place of Service Codes

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

POS	*Description*
11	Office
12	Home
15	Mobile Dental Clinic
21	Inpatient Hospital
22	Outpatient Hospital
24	Ambulatory Surgical Center
31	Skilled Nursing Facility
32	Nursing Facility
54	Intermediate Care Facility/Individuals with Intellectual Disabilities

NOTE:

Outpatient surgery, outpatient hospital visits, and nursing facility visits should be billed using the FQHC number for the physician rendering services. Do not bill these services on the same claim as other FQHC services.

16.6.4 Required Attachments

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

- Claims with Third Party Denials
- When an attachment is required, a hard copy CMS-1500 claim form must be submitted.

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16.7 For More Information

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

Resource	Where to Find It
CMS-1500 Claim Filing Instructions	Chapter 5
Medical Medicaid/Medicare-related Claim Filing Instructions	Chapter 5
Medical Necessity/Medically Necessary Care	Chapter 7
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

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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 or non-physician practitioner's (NPP) office, clinic, or other outpatient setting for required treatment; as a result, he or she would, in all probability, have to be admitted to the hospital or nursing home because of complications arising from lack of treatment.
- The recipient is unable to function without the aid of supportive devices, such as crutches, a cane, wheelchair or walker; requires the use of special transportation or the assistance of another person.

The patient's attending physician or NPP 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 or NPP must re-certify care every 60 days if home services continue to be necessary. The attending physician or NPP must be a licensed, active Medicaid provider.

For the initial ordering of home health services (nursing services and home health aide services), the physician or NPP who develops the recipient's written plan of care must sign and document that a face-to-face encounter is related to the primary reason the beneficiary requires home health services. The face to face encounter is conducted by a physician or NPP no more than 90 days before or 30 days after the start of services. The face-to-face encounter may be conducted by either a physician or one of the following authorized non-physician practitioners working under a collaboration agreement under Alabama law:

- Certified Nurse Practitioners or Clinical Nurse Specialists
- Certified nurse midwifes
- Physician assistants, or
- Attending acute or post-acute physicians, if recipients are admitted to home health services immediately after discharge from an acute or post-acute stay.

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The face-to-face encounters may be conducted using telehealth systems.

Refer to Chapter 14—Durable Medical Equipment (DME), Supplies, Appliances, Prosthetics, Orthotics and Pedorthics (POP), for more information on the requirements for placing the initial ordering of certain medical supplies, equipment, and appliances.

The policy provisions for home health providers can be found in the *Alabama Medicaid Agency Administrative Code,* Chapter 12.

17.1 Enrollment

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

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

To become a home health provider, a provider must be a public agency, private non-profit organization, or proprietary agency primarily engaged in providing part-time or intermittent skilled nursing and home health aide services to patients in their homes. Only in-state home health agencies are eligible for participation in Medicaid.

National Provider Identifier, Type, and Specialty

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

NOTE:
The 10-digit NPI is required when filing a claim.

Home health providers are assigned a provider type of 5 (Home Health). The valid specialty for home health providers is 050 (Home Health).

Enrollment Policy for Home Health Providers

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

- Be certified to participate as a Medicare provider
- Be certified by the Division of Licensure and Certification of the Alabama Department of Public Health as meeting specific statutory requirements and the Conditions of Participation

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

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Change of Ownership (CHOW) and Closures

Medicaid will mirror Medicare's Change of Ownership (CHOW) policy. Refer to Chapter 19, Hospital for additional information on Change of Ownership.

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. Refer to Chapter 7, Understanding Your Rights and Responsibilities as a Provider, for general criteria on Medical Necessity/ Medically Necessary Care.

17.2.1 Covered Services

Registered Nurse Services (RN)

If ordered by the patient's attending physician or NPP, 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 or NPP 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 or NPP, 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 or NPP plan of care.

Supervisory visits by the registered nurse must be performed at least every 60 days when services are provided by the LPN, home health aide, or orderly. These services may be provided on a part-time basis only and must be ordered by the attending physician or NPP. 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.

Medicaid also does not cover sitter service, medical social workers, or dietitians.

Supervisory visits made by an RN to evaluate appropriateness of services being rendered to a patient by an LPN, aide, or orderly are considered administrative costs and may not be billed as skilled nursing services. The registered nurse will provide and document in the case record on-site

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supervision of the LPN, home health aide, or orderly at least every 60 days. The registered nurse will conduct on-site supervision more frequently if warranted by complaints or suspicion of substandard performances by the worker.

17.2.3 Visits

A visit is a personal contact in the place of residence of a patient by a health worker employed by a certified Medicaid home health agency for the purpose of providing a covered service.

Home health care visits to Medicaid recipients must be medically necessary and provided in accordance with a Medicaid Home Health Certification form signed by a licensed physician or NPP. 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

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 Alabama Coordinated Health Network (ACHN) Program, refer to Chapter40 ACHN Billing Manual to determine whether your services require a referral from the Primary Care Physician (PCP).

17.4 Cost Sharing (Copayment)

Copayment does not apply to services provided by home health providers.

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17.5 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers are encouraged to bill Medicaid claims electronically.

Home health providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When filing a claim on paper, a UB-04 claim form is required. Medicare-related claims must be filed using the Institutional Medicaid/Medicare Related Claim Form.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

17.5.1 Time Limit for Filing Claims

Medicaid requires all claims for home health to be filed within one year of the date of service. Refer to Section 5.1.4, Filing Limits, for more information regarding timely filing limits and exceptions.

17.5.2 Diagnosis Codes

The *International Classification of Diseases - 10th Revision - Clinical Modification* (ICD-10-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the
American Medical Association, AMA Plaza 330 North Wabash Ave, Suite 39300 Chicago, IL 60611-5885, or 1-800-621-8335.

NOTE:

ICD-9 codes should be used for claims submitted with dates of service prior to or equal to 09/30/2015.

ICD-10 codes should be used for claims submitted with dates of service on/after 10/01/2015.

NOTE:

ICD-9 or ICD-10 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.

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17.5.3 Procedure Codes and Modifiers

The following procedure codes apply when filing claims for home health services. Medicaid requires all claims for home health providers to be filed within one year of the date of service. Refer to Chapter 5, for general claims filing information and instructions.

Home Health Services

Revenue Code	*Procedure Code*	*Description*
551	S9124	Nursing care in the home by LPN; per hour
551	S9123	Nursing care in the home by RN; per hour
571	S9122	Home Health aide or CNA providing care in the home; per hour

Billing for Supplies

Home health providers must enroll as a DME provider to bill for supplies. Supplies may not be billed on a UB-04 claim form.

17.5.4 Place of Service Codes

Place of service codes do not apply when filing the UB-04claim form.

17.5.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to Claims with Third Party Denials.

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

NOTE:
When an attachment is required, a hard copy UB-04 claim form must be submitted.

17.6 For More Information

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

Resource	Where to Find It
UB-04 Claim Filing Instructions	Section 5.3
Institutional Medicaid/Medicare-related Claim Filing Instructions	Section 5.6.2
Medical Necessity/Medically Necessary Care	Chapter 7
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N

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18 Hospice

Hospice is an interdisciplinary program of palliative care and supportive services that address the physical, spiritual, psychosocial, and economic needs of terminally ill patients and their families. This care may be provided in the patient's home or in a nursing facility, if that is the recipient's place of residence.

The Alabama Medicaid Hospice Care Services Program began October 1, 1990, in order to help people who meet the criteria for hospice services remain in their homes.

Medicaid offers hospice care services to Medicaid-eligible recipients who are terminally ill as certified by the medical director of the hospice, or by the physician member of the hospice inter-disciplinary group and the individual's attending physician, if present. An individual is considered to be terminally ill if the medical prognosis indicates a life expectancy of six months or less. Hospice care consists of services necessary to relieve or reduce symptoms of the terminal illness and related conditions.

Medicaid hospice care services are subject to Medicare special election periods applicable to hospice care. Medicaid uses the most recent benefit periods established by the Medicare Program.

Effective June 16, 2005, all Hospice Providers are required to use criteria specific to the Medicaid program to determine medical necessity for recipients electing the hospice benefit when Medicaid is the primary payor. Providers should no longer use the Palmetto GBA Medicare Local Medical Review Policy (LMRP) to determine medical necessity for the hospice program when Medicaid is the primary payor for the hospice services. Providers should continue to use the Palmetto GBA LMRP for dually eligible recipients with Medicare Part A who reside in the community or a nursing facility because Medicare is considered the primary payor for these individuals. The Medicaid hospice criteria should be used to establish eligibility for the following categories of hospice recipients:

- All recipients with full Medicaid benefits
- All recipients with Medicaid and Medicare Part B
- All recipients who are Qualified Medicare Beneficiaries (QMBs) with full Medicaid coverage.

The policy provisions for Hospice providers can be found in Chapter 51 of the *Alabama Medicaid Agency Administrative Code,* and on the agency website *at* www.medicaid.alabama.gov. For diagnoses not found in the Alabama Medicaid Agency Administrative Code for cases with evidence of other co-morbidities and the evidence of rapid decline and for pediatric cases medical necessity review will be conducted on a case-by-case basis.

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18.1 Enrollment

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

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

National Provider Identifier, Type, and Specialty

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

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

NOTE:
The 10-digit NPI is required when filing a claim.

Hospice providers are assigned a provider type of 06(Hospice). Valid specialties for hospice providers include Hospice (060).

Enrollment Policy for Hospice Providers

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

Receive certification from the Centers for Medicare and Medicaid Services that the hospice meets the conditions to participate in the Medicare program.

- Possess a letter from the state licensing unit showing the permit number and effective date of the permit
- Possess a document from the licensing unit showing that the hospice meets requirements for the Medicare program
- Possess a signed document indicating that the hospice is in compliance with Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975
- Possess a copy of the written notification to the hospice from the Medicare fiscal intermediary showing the approved Medicare reimbursement rate, the fiscal year end, and the NPI
- The Alabama Medicaid Agency will initiate recoupment of payment for services when it determines that state and federal medical necessity and eligibility requirements are not met.
- Multiple location means a Medicare-approved location from which the hospice provides the same full range of hospice care and services that is required of the hospice who is issued the certification number. These

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locations also require Medicaid enrollment to enable proper reimbursement rates.

- **A multiple location must meet all of the conditions of participation applicable to hospices.**

Change of Ownership (CHOW) and Closures

Medicaid will mirror Medicare's Change of Ownership (CHOW) policy. Refer to Chapter 19, Hospital for additional information on Change of Ownership.

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. Refer to Chapter 7, Understanding Your Rights and Responsibilities as a Provider, for general criteria on Medical Necessity/ Medically Necessary Care.

Hospice providers must establish and maintain a written plan of care for each individual admitted to a hospice program. All services provided by the hospice must adhere to the plan. When discharging a recipient, hospice providers must follow state and federal guidelines (Code of *Federal Regulations* § 418.26 Discharge from Hospice Care).

The hospice must submit required hospice election and physician certification documentation to Medicaid, or its designee, for coverage of hospice care. If the hospice provider submits documentation which appears to be incomplete (i.e. Medicaid Hospice Election Form 165 is missing or incomplete, etc.), the provider will receive a letter requesting the additional information. If the additional information is not received within 30 days, the application will be denied. This information shall be kept on file and shall be made available to the Alabama Medicaid Agency for auditing purposes.

18.2.1 Physician Certification

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

For the first period, the hospice provider must obtain written certification statements signed by the medical director of the hospice or the physician member of the interdisciplinary team and the recipient's attending physician, if present. The hospice must obtain physician certification no later than two calendar days after hospice care begins.

If the hospice provider does not obtain written certification as described, the hospice may obtain verbal certification within the two-day period, but must obtain written certification no later than 30 calendar days after care begins. If every effort is made to secure written certification within 30 calendar days and the hospice provider has not obtained the written certification, then a physician signature obtained by fax will meet the certification requirement. Written certification must be secured and retained in the client record within 30 days of the hospice election.

For each subsequent period, the hospice may submit written certification as early as 15 days before the subsequent period begins, but in no event may the written certification be submitted later than two calendar days after the beginning of a subsequent period.

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Each written certification must indicate that the recipient's medical prognosis is such that his or her life expectancy is six months or less. The hospice must retain these certification statements.

Signature Requirement

For information regarding electronic signature, refer to ***Chapter 1 – General Chapter (Rule No. 560-X-1-.18)*** of the Administrative Code.

18.2.2 Election Procedures

In order to receive hospice care benefits, an individual must qualify for Medicaid and be certified as terminally ill by a doctor of medicine or osteopathy.

An election period is a predetermined timeframe for which an individual may elect to receive medical coverage of hospice care. Individuals may receive hospice care for two 90-day election periods, followed by an unlimited number of subsequent periods of 60 days each.

An individual eligible for hospice care must file an election certification statement with a particular hospice. Beginning April 1, 2005, all Hospice providers must complete the Medicaid Hospice Election and Physician's Certification Form 165 to certify Medicaid recipients for the hospice program. The Medicaid Agency will recognize the Medicare election form as election for both Medicare and Medicaid for dually eligible recipients receiving hospice services. When a dually eligible recipient enters the nursing facility the Hospice Recipient Status Change Form 165B must be completed and returned to the Alabama Medicaid Agency, or its designee. Hospice providers must also use this form to report subsequent changes for all hospice recipients during the hospice certification period. Due to the terminally ill individual's mental or physical incapacity, a representative may be authorized to file an election.

An election to receive hospice care is considered to continue from the initial election period through the subsequent election periods without a break in care as long as the following criteria are met:

- Recipient remains in the care of a hospice
- Recipient does not revoke the election provisions
- Recipient is not discharged from the hospice under the provisions of §418.26.

An individual or representative may designate an effective date that begins with the first day of hospice care or any subsequent day of hospice care. The two 90-day election periods must be used before the 60-day periods. If an individual revokes the hospice election, any days remaining in that election period are forfeited. An individual or representative may not designate an effective date earlier than the date that hospice care begins. A Medicaid beneficiary who resides in a nursing facility may elect to receive hospice services. The hospice must have a contract with the nursing facility that clearly states which services each has responsibility to provide and details how the nursing facility and hospice will work together.

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18.2.3 Medical Records

The hospice has the responsibility to establish and maintain a permanent medical record for each patient that includes the following:

- Physician certifications
- Services provided
- Recipient election statement(s)
- Interdisciplinary treatment plan of care and updates
- Advance directive documentation

The documentation contained in the medical record must be a chronological, complete record of the care provided to the hospice recipient. The medical record must contain the Medicaid Hospice Election and Physician's Certification, Form 165 that is signed and dated by the physician. A Form 165 must be present for each election period. The documentation must contain the physicians' orders that include medication(s) taken by the recipient, an assessment and a plan of care developed prior to providing care by the attending physician, the medical director or physician designee, and the interdisciplinary team. Identification of a specific terminal illness must be documented and substantiated by labs, x-rays and other medical documentation supporting the terminal illness as set forth by the Medicaid guidelines.

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

Recipients residing in nursing facilities that elect the hospice benefit, but are subsequently determined to be ineligible for hospice care by Medicare or Medicaid, are not automatically approved for Medicaid reimbursement for nursing facility care if hospice payments are denied or recouped. Election of hospice care forfeits other Medicaid benefits.

Recipients who are denied hospice benefits in the nursing facility who intend to remain in the facility must apply and meet the nursing facility level of care criteria and the financial criteria for nursing home coverage by Medicaid.

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

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- Any Medicaid services that are equivalent to hospice care

Individuals receiving hospice care **do not waive** the following benefits:

- Services provided by the designated hospice
- Services provided by another hospice under arrangements made by the designated hospice
- Services provided by the individual's attending physician if that physician is not an employee of and does not receive compensation from the designated hospice for those services
- Medicaid-covered services that are not related to the hospice recipient's terminal illness

NOTE:

Children under the age of 21 can now receive services related to the treatment of the condition for which a diagnosis of terminal illness was made.

18.2.6 Election Revocation

An individual or representative may revoke the individual's election of hospice care at any time during an election period. If an individual revokes the election to receive hospice care, any days remaining in that election period are forfeited.

The hospice sends the Alabama Medicaid Hospice Care Program the **Hospice Recipient Status Change Form 165B** to revoke the individual's election for Medicaid coverage of hospice care.

Upon revocation of the election of Medicaid coverage of hospice care, an otherwise Medicaid eligible recipient resumes Medicaid coverage of the benefits waived when hospice care was elected.

NOTE:

An individual should not revoke the hospice benefit when admitted to the hospital for a condition related to the terminal illness for the purpose of pain control or acute or chronic symptom management.

18.2.7 Change of Hospice

An individual or representative may change the designation of the particular hospice that provides hospice care one time per election period. The change of the designated hospice is not a revocation of the election for the period in which it is made.

To change the designated hospice provider, the individual or representative must file a signed statement that includes the following information:

- The name of the hospice from which care has been received
- The name of the hospice from which the individual plans to receive care
- The effective date of the hospice change
- The hospice provider transferring the recipient should submit a Hospice Recipient Status Change Form 165B indicating transfer of the recipient

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- The accepting hospice provider should submit documentation to the Alabama Medicaid Agency, or its designee, for review and processing to the LTC file. (Form 165B LTC Hospice Recipient Status Change). The new provider must explain on Form 165B that this is a transfer from another hospice provider
- The approval letter from the previous hospice provider
- If Form 165B from the previous provider indicating the discharge date is available, the new provider should submit that documentation as well

The individual or representative must provide a copy of this statement to the hospice provider and to Medicaid.

The waiver of other benefits remains in effect.

18.2.8 Covered Services

Nursing care, physician services, medical social services, and counseling are core hospice services routinely provided directly by hospice employees.

Appropriately qualified personnel as determined by the nature of the service must perform all covered services.

The following are covered hospice services:

Covered Services	***Description***
Nursing facility care	Provided by or under the supervision of a registered nurse
Medical social services	Provided by a social worker who has at least a bachelor's degree from an approved or accredited school and who works under the direction of a physician
Physician services	Performed by a licensed physician. The medical director and physician member of the interdisciplinary group must be a doctor of medicine or osteopathy.
Counseling services	Provided to the terminally ill individual and the family or other person(s) caring for the patient at home. Counseling includes dietary advice, caregiver training, and counseling for adjustment to approaching death for patients and caregivers.
Short-term inpatient care	Provided in a participating hospice inpatient unit or a hospital or nursing facility that provides services through a contract with the hospice. General inpatient procedures necessary for pain control or acute or chronic symptom management that cannot be provided in another setting; respite inpatient care lasting up to five consecutive days may provide relief for the individual's caregiver at home. Medicaid will not cover respite care when the recipient is a nursing facility resident. These inpatient services must be part of the written plan of care.
Medical appliances and supplies	Includes drugs and biologicals provided to the patient. Drugs must be used primarily for relief of pain and symptom control related to the individual's terminal illness and related conditions. Appliances include durable medical equipment as well as other self-help and personal comfort items provided by the hospice for use in the patient's home for the palliation or management of the patient's terminal illness and/or related condition. These appliances and supplies must be included in the written plan of care.
Home health aide services	Furnished by qualified aides and homemaker services provided under the general supervision of a registered nurse. These services include personal care and maintenance of a safe and healthy environment as outlined in the plan of care.

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Covered Services	*Description*
Physical Therapy, Occupational Therapy, and Speech Language Pathology	Provided for symptom control or to allow the recipient to maintain basic functional skills and/or activities of daily living

Hospices may contract for supplemental services during periods of peak patient loads and to obtain physician specialty services.

18.2.9 Reimbursement for Levels of Care

With the exception of payment for direct patient care services by physicians, Medicaid pays the hospice for all covered services related to the treatment of the recipient's terminal illness for each day the recipient is Medicaid-eligible and under the care of the hospice, regardless of the services furnished on any given day.

Payment for hospice care shall conform to the methodology and amounts calculated by the Centers for Medicare and Medicaid Services (CMS). Medicaid bases hospice payment rates on the same methodology used to set Medicare rates and adjusts rates to disregard offsets due to Medicare co-insurance amounts. Each rate comes from a CMS estimate of the costs generally incurred by a hospice in efficiently providing hospice care services to Medicaid beneficiaries. Medicaid adjusts the rates of reimbursement to reflect local differences in wages.

Medicaid pays reimbursements to the dispensing pharmacy for drugs not related to the recipient's terminal illness through the Medicaid Pharmacy Program.

The Alabama Medicaid Agency will initiate recoupment of payment for services when it determines that state and federal medical necessity and eligibility requirements are not met.

Claims Processing for the Hospice Program

Medicare pays 100% of hospice care if a Medicare/Medicaid (dually eligible) recipient meets Medicare’s criteria.

- For a dually eligible recipient in the community, the recipient is not on the Level of Care panel; therefore, Hospice does not bill Medicaid for Medicare services.
- For a dually eligible recipient in a nursing facility, for each day service is rendered, the recipient is on the Level of Care panel; however, Hospice only bills Medicaid for 95% Room & Board for the days Medicaid would have reimbursed if the nursing facility was billing Medicaid directly. Hospice is to bill Medicare for routine care services.
- For a Medicaid only recipient (meaning Non-Medicare) in the community, the hospice provider is on the Level of Care panel. Hospice bills Medicaid for every day the provider renders service at the appropriate care level (Revenue Code 651/Procedure Code T2042 or Revenue Code 651/Procedure Code T2042 for Routine Home Care **or** Revenue Code 652/Procedure Code T2042-SC for Continuous Home Care).

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- For a Medicaid only recipient in a nursing facility, the recipient is on the Level of Care panel. Hospice bills Medicaid for the appropriate care level for every day service is render + 95% Room & Board for the days Medicaid would have reimbursed if the nursing facility was billing Medicaid directly. (Revenue Code 659/Procedure Code T2046 or Revenue Code 659/Procedure Code T2046).
- For a Medicaid only recipient in the community or the Nursing Facility, the recipient is on the Level of Care panel. Hospice bills Medicaid for Routine Home Care and may also bill as a Service Intensity Add On (SIA) for a Registered Nurse RN or Social Worker up to 4 hours per day during the last 7 days of life of the recipient. (Revenue Code 651/Procedure Code G0299 Registered Nurse RN or Revenue Code 651/Procedure Code G0155 Social Worker).
- Hospice Providers will be required to span bill claims (up to one month) – billing only one detail line per claim.
- Hospice Providers should bill one procedure code for one unit/per day of service for all hospice procedure codes except *T2045 General Inpatient Care/per day,* which can be billed with *T2042 Routine Home Care/per day*. T2042 should be billed on a separate claim with overlapping dates of service.

This does not include *T2042-SC Continuous Care*. The Continuous Care billed amount must be calculated based upon the number of hours of care provided. The units will continue to be based upon the number of days.

NOTE:

For a straight Medicaid recipient, Medicaid will reimburse Hospice care for *Date of Death* or *Discharge* when the recipient is in a nursing facility, but will not reimburse for room and board.

When a recipient is discharged from Hospice and transfers to a nursing facility, Hospice should bill for the Date of Discharge and the nursing facility should bill for the next day. The nursing facility is paid for the admission date and the hospice provider is paid for the day of discharge. Hospice is responsible for reimbursing the nursing facility for the Room & Board for every day that the Hospice is on the Level of Care file as rendering services. The nursing facility should submit a new admission for the first day that the nursing facility would have billed the Agency for rendered services.

NOTE:

Reimbursement for disease specific drugs related to the recipient's terminal illness as well as drugs found on the Hospice Palliative Drug List (HPDL) are included in the per diem rates for hospice covered services and will not be reimbursed through the Medicaid Pharmacy Program. The HPDL is on the agency website *at* *www.medicaid.alabama.gov.*

With the exception of payment for physician services, Medicaid reimburses hospice care at one of four rates for each day in which a Medicaid recipient receives hospice care with the option of an intensity add on rate that may only be billed with routine home care rate. The payment amounts are determined within each of the following categories:

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- 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.

Routine Home Care Service Intensity Add-On

The hospice receives reimbursement for service intensity add-on when a social worker or registered nurse (RN) makes a visit during routine home care in the last seven days of life. The SIA payment is in addition to the routine home care rate. This rate also applies to Medicaid recipients residing in the nursing facility.

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.

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Group activities, which include participation in establishing plans of care, supervising care and services, periodically reviewing and updating plans of care, and establishing governing policies are included in the reimbursement rates for routine home care, continuous home care, and inpatient respite care. Direct patient care services by physicians are reimbursed as follows:

- Physicians employed by or working under arrangements made with the hospice may bill for direct patient care services rendered.
- Services provided by the attending physician who is not employed by or receiving compensation from the hospice will be paid to that physician in accordance with the usual billing procedures for physicians. Refer to Chapter 28, Physician, for physician billing procedures.
- Services furnished voluntarily by physicians where the hospice has no payment liability are not reimbursable.

Nursing Facility Residents

Medicaid will not restrict hospice services based on a patient's place of residence. A nursing facility resident may elect to receive hospice benefits if he or she meets the requirements for hospice care under the Medicaid program.

If the resident elects to receive hospice benefits, the nursing facility submits discharge information per LTC Admission Notification Software.

A Medicaid hospice recipient residing at home who enters a nursing facility may continue to receive services under the hospice benefit. Any applicable resource liability amount and/or third party liability amount for a nursing facility resident need to be established and applied to the amount paid to the hospice by Medicaid for the nursing facility services. Nursing facility residents are required to use income to offset the cost of nursing facility care. Additionally, if a resident in a nursing facility elects, the hospice income will be applied to offset the cost of hospice care. The Medicaid district office will provide the hospice provider a copy of the Notice of Award or Notice of Change of Liability in order to inform the hospice of the claimant’s liability required amount to be paid from claimant’s income.

The Hospice Provider should use the Hospice Recipient Status Change Form 165B to report the following information to the Alabama Medicaid Agency, or its designee, for **dually eligible** institutionalized recipients:

- Initial nursing home admission
- Discharge from the nursing home to the hospital
- Discharge from the nursing home to the community
- Expiration in the nursing home
- Readmission to the nursing home from the hospital after an unrelated hospital stay

The Hospice Provider should use the Hospice Recipient Status Change Form 165B to report the following information to the Alabama Medicaid Agency, or its designee, for **Medicaid Only** institutionalized and/or recipients in the community:

- Discharge from the nursing home to the hospital

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- Discharge from the nursing home to the community
- Discharge, revocation or death
- Expiration in the nursing home
- Readmission to the nursing home or the community from the hospital after an unrelated hospital stay

NOTE:

Medicaid pays the hospice 95% of the nursing home rate applicable for that year for the room and board that would have been paid to the nursing facility for that individual under the State Plan. Providers should submit to Medicaid for reimbursement 95% of the Medicaid per diem rate for the nursing home in which the recipient resides. For Nursing Home claims regarding patient days, Medicaid covers the day of admission, but not the day of discharge, or the date of death.

Medicare/Medicaid Eligibility

The Hospice Election and Physicians Certification Form 165 must be completed for all recipients who are Medicaid eligible. However, for dually eligible recipients who have Medicare Part A, Medicare will pay the daily hospice rate for the appropriate level of care – routine, continuous, inpatient respite, or general inpatient.

If the dually eligible hospice recipient with Part A Medicare resides in a nursing facility, Medicare pays the daily hospice rate as usual. Providers should submit to Medicaid for reimbursement 95% of the Medicaid per diem rate for the nursing home in which the recipient resides. The number of days of Medicare coverage must equal the number of days requested for nursing facility room and board. Any applicable resource liability amount and/or third party liability amount is deducted from the payment made to the Hospice provider for the facility services.

The Qualified Medicare Beneficiary (QMB) recipient who has **QMB-only** is not eligible for any Medicaid benefits, i.e., home health, hospice, medications, etc. A recipient who has **QMB+** does have full Medicaid benefits and would be eligible for home health, hospice, and medications.

Coinsurance amounts for drugs and biologicals or respite care may be billed to Medicaid as crossover claims for dually eligible recipients for whom Medicare is the primary payer.

Drugs and biologicals furnished by the hospital while the recipient is not an inpatient may be billed at 5 percent of the cost of the drug or biologicals, not to exceed $5.00 per prescription.

Medicaid Waiver Eligibility

A Medicaid-only recipient cannot receive hospice services and waiver services simultaneously; however, a Medicare/Medicaid-eligible recipient may receive the hospice benefit and waiver service if Medicare is the payer for the hospice service. The hospice provider must inform Medicaid recipients receiving Medicaid Waiver Services that they will lose Medicaid Waiver Services when they elect to receive hospice benefits and notify the Waiver Provider of the election of the hospice benefit.

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Audits

The provider of hospice care may be asked to furnish the Medicaid Hospice Care Program with information regarding claims submitted to Medicaid. The provider of hospice care must permit access to all Medicaid records and facilities for the purpose of claims audit, program monitoring, and utilization review by duly authorized representatives of federal and state agencies.

The provider of hospice care must maintain complete and accurate medical and fiscal records that fully disclose the extent of the services and billings. The provider retains these records for the period of time required by state and federal laws.

Inpatient Respite Care

Medicaid pays coinsurance claims for inpatient respite care, drugs, and biologicals for dually eligible recipients. Medicaid pays 5 percent of the Medicare payment for a day of respite care. This payment will not exceed the inpatient hospital deductible applicable for the year in which the hospice co-insurance period began. Medicaid will not pay for more than five consecutive days.

Medicaid pays 5 percent of the cost of each palliative drug and biological prescription furnished by the hospice while the individual is not an inpatient. The cost may not exceed $5.00 for each prescription.

NOTE:
When filing coinsurance claims for inpatient respite care or for drugs and biologicals, the provider must complete the UB-04 claim form.

18.3 Medicaid Approval for Hospice Care

Providers must adhere to all state and federal specific timeframes and documentation requirements under the Medicaid Hospice Program.

Effective February 1, 2006, all hospice providers are subject to a 100% review of medical records containing documentation of admission; including hospice stays of six months or more. Hospice providers will no longer have the ability to submit dates of service to the LTC file for hospice admission or recertification.

Policies and Procedures for Hospice Admission and Recertification

- Applicants to Medicaid approved hospice providers must be certified, by their attending physician or hospice medical director, to have a terminal illness with a life expectancy of six months or less. The certification for terminal illness is substantiated by specific findings and other medical documentation including, but not limited to, medical records, labs, x-rays, pathology reports, etc.
- The hospice provider will be required to comply with all state and federal rules related to an individual's election of the hospice benefit.
- The hospice provider must establish a permanent medical record for each patient which documents eligibility for the Medicaid Hospice benefit based upon the medical criteria found in the Alabama Medicaid Agency Administrative Code Rule 560-X-51-.04. For cases with evidence of other

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co-morbidities and the evidence of rapid decline and for pediatric cases, medical necessity review will be conducted on a case-by-case basis.

- All hospice providers certifying patient initial admission, recertification or hospice stays for six months or more must submit medical documentation to the Alabama Medicaid Agency or its designee for review. When approved the Alabama Medicaid Agency or its designee will enter the dates of service through the LTC notification software.
- Hospice recipients who are in a nursing home with a third party insurance as the primary payer for hospice care, do not require a medical review to receive room and board payment by Medicaid. Hospice providers are required to submit to Medicaid or it's designee a Form 165B, proof of insurance coverage, and paid claims (such as an EOP) from the third party payer to be approved for room and board payment by Medicaid. The hospice provider will be added to the LTC file and should submit for reimbursement at 95% of the Medicaid per diem rate for the nursing home in which the recipient resides.
- When submitting records the LTC Gainwell Cover Sheet from the web portal must accompany the medical record. Hospice records for approval may be uploaded two different ways:
    - Medicaid Interactive Web Portal (preferred) https://www.medicaid.alabamaservices.org/ALPortal/Account/Secure%20-Site/tabId/66/Default.aspx
    - Fax information in for processing (bar coded cover sheet required)

Documents must be in a Portable Document Format (PDF) for upload through the Medicaid web portal. If you do not currently have the ability to create PDF versions of medical records, you may perform an internet search and find free downloadable utilities that can be installed to create a PDF. For your convenience, a list of three PDF creation utilities that can be installed to create PDF documents at no charge.

- PrimoPDF – http://www.primopdf.com/
- Solid PDF Creator - http://www.freepdfcreator.org/
- PDF24 – http://pdf24-pdf-creator.en.softonic.com/

Once a PDF utility has been successfully downloaded and the PDF document created, providers should follow these steps to upload documentation for review:

1. Log on to Medical Interactive Web portal:

   https://www.medicaid.alabamaservices.org/ALPortal/Account/Secure%20-Site/tabId/66/Default.aspx
2. Select Trade Files/Forms.

Forms Name field – select a form from the drop down list and click on "Search". The following is a list of forms available for selection,

   a. LTC – Hospice Records
   b. LTC – Records

3. Complete all fields (record ID field will auto populate). Required
4. Click on 'Browse' and select the required medical records documentation from your network drive or PC and select 'Submit'.

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5. A message will be generated that states 'your form was submitted successfully' at the top of the page.
6. A barcode coversheet is generated and will be displayed.
7. Select the 'Print Friendly View' button to print the barcode coversheet or to save as a PDF. A copy of this barcode coversheet should be saved in the event additional documentation is required.

If a PDF document of the medical records cannot be created, information may also be faxed for review. A fax cover sheet will be required with each submission; providers should follow the instructions below to fax documentation:

1. Follow steps 1-7 documented above.
2. Fax the required medical records documentation with the barcode coversheet on top of the documentation to 334-215-7416.Include the bar coded cover sheet with each submission for the same recipient.
3. Do not fax double sided pages.
4. Do not fax multiple sets of records at the same time, each fax should be sent separately.

NOTE:

The bar code cover sheet is required for each fax submission for the same recipient. A fax submission cannot be processed without the bar coded cover sheet. DO NOT place anything on the bar code on the cover sheet or alter it any manner.

The Alabama Medicaid Agency or its designee's Nurse Reviewer will review the documentation to ensure the appropriateness of admission based on Medicaid's medical criteria for admission as defined in the Alabama Medicaid Agency Administrative Code Rule No. 560-X-51-.04.

- If there are no established criteria for the admitting hospice diagnosis, the Nurse Reviewer will perform a preliminary review of the documentation for terminality and the normal progression of the terminal disease. The Medicaid Agency's Medical Director will make the final determination of approval or denial of the admission and continued stay in the Hospice Program for those diagnoses which have no established medical criteria.
- A person who reaches a point of stability and is no longer considered terminally ill must not be recertified for hospice services. The individual must be discharged to traditional Medicaid benefits.
- Individuals seeking aggressive treatment shall not be certified for hospice services. "Aggressive treatment" means treatment that is intended to be life-prolonging or curative (rather than palliative) and would prevent the natural course of the terminal illness upon which they are seeking hospice services.
- When there is both medical and financial approval, the application dates will be entered through the LTC notification software by the Alabama Medicaid Agency or its designee.
- If the hospice provider submits documentation which appears to be incomplete (i.e. Medicaid Hospice Election Form 165 is missing or incomplete, etc.) the provider will receive a letter requesting the additional

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information. If the additional information is not received within 30 days the application will be denied.

- No hospice segment will be approved by the Alabama Medicaid Agency or its designee for greater than six months. If a recipient remains on hospice beyond six months, the provider must submit documentation which supports continued appropriateness for hospice including documentation of the continued progression of the disease. This information should be forwarded to the Alabama Medicaid Agency or its designee for review two weeks prior to the end of the six month certification period or the case will automatically close. If the documentation demonstrates progression of the terminal illness, then an additional six month certification period will be established and added to the LTC file by the Alabama Medicaid Agency or its designee.

- An approval or denial letter will be faxed or mailed to the provider upon completion of the review. The approval or denial letter notifies the provider of the dates added to the file and may be used for billing of hospice claims.
- All revocations, discharges, deaths and readmissions after an unrelated hospital stay should be faxed to the Alabama Medicaid Agency or its designee using the Hospice Recipient Status Change Form 165B. Readmissions should include the previous six month admission approval letter.

18.4 Cost Sharing (Copayment)

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

18.5 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers are encouraged to bill Medicaid claims electronically.

Hospice providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When filing a claim on paper, a hard copy UB-04 claim form is required.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

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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 5.1.5, Filing Limits and Approved Exceptions, for more information regarding timely filing limits and exceptions.

18.5.2 Diagnosis Codes

The International *Classification of Diseases - 10th Revision - Clinical Modification* (ICD-10-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the
American Medical Association, AMA Plaza 330 North Wabash Ave, Suite 39300 Chicago, IL 60611-5885, or 1-800-621-8335.

NOTE:

ICD-9 codes should be used for claims submitted with dates of service prior to or equal to 09/30/2015.

ICD-10 codes should be used for claims submitted with dates of service on/after 10/01/2015.

NOTE:

ICD-9 or ICD-10 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

18.5.3 Procedure Codes, Revenue Codes and Modifiers

Hospice providers are required to use HCPCS procedure codes for each service rendered. Failure to identify each service with a procedure code will result in denial of the service. The (837) Institutional electronic claim and the paper claim have been modified to accept up to four Procedure Code Modifiers.

Payment of hospice services is limited to the following codes:

Revenue Code	*Procedure Code*	*Description*
651	T2042 T2042 G0155 G0299	Routine home care, per days 1-60 Routine home care, per days 61+ Clinical Social Worker, SIA, last 7days of life Registered Nurse (RN), SIA, last 7 days of life
652	T2042-SC	Continuous home care, per day
655	T2044	Inpatient respite care, per day
656	T2045	General inpatient care, per day
659	T2046 T2046 T2046-SC T2046-SE	Nursing facility room and board, Routine care, per days 1-60 Nursing facility room and board, Routine care, per days 61+ Nursing facility room and board, Continuous care, per day Nursing facility room and board, per dually eligible recipient, per day

NOTE:

For Medicaid recipients with another insurance which pays for routine care in the nursing home, submit T2046. Document the other insurance

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paid amount for routine care in block 54 of the UB-04, along with the other insurance information in the appropriate blocks of the claim form.

18.5.4 Place of Service Codes

Place of service codes do not apply when filing the UB-04 claim form.

18.5.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to claims with third party denials.

NOTE:

When an attachment is required, a hard copy UB-04 claim form must be submitted.

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

18.6 For More Information

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

Resource	Where to Find It
UB-04 Claim Filing Instructions	Chapter 5
Medical Necessity/Medically Necessary Care	Chapter 7
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

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

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

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

National Provider Identifier, Type, and Specialty

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

NOTE:
The 10-digit NPI is required when filing a claim.

Hospitals are assigned a provider type of 01 (Hospital). Valid specialties for hospitals include the following:

- Acute Care Hospital (010)
- Inpatient Psychiatric Hospital 65 or over (011)
- Psychiatric Residential Treatment Facility (013)
- Inpatient Psychiatric Hospital under 21 (017)
- Mammography (292)
- Lithotripsy (520)

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- Organ Transplants (530)
- Post-Extended Care (PEC) Hospital (540)
- QMB/EPSDT (600)
- QMB only (610)
- VFC (900)
- Rehabilitation CORF (012)—for crossover claims only
- Long Term Care Hospital (014)—for crossover claims only
- Psych Subpart Enrollment (018)—for crossover claims only
- Rehab Subpart Enrollment (019)—for crossover claims only

Enrollment Policy for Hospital Providers

In order to participate in the Alabama Medicaid Program and to receive Medicaid payment for inpatient and outpatient hospital services, a hospital provider must meet the following requirements:

- Receive certification for participation in the Title XVIII Medicare and Title XIX Medicaid programs as a short term or children's hospital. Hospital types are identified on the “Hospital/CAH Medicare Database Worksheet” completed by the State Agency Surveyor.
- Possess a license as a hospital by the state of Alabama in accordance with current rules contained in the *Rules of Alabama State Board of Health Division of Licensure and Certification* Chapter 420-5-7.
- Submit a budget of cost for medical inpatient services for its initial cost reporting period, if a new facility. Not required for facilities filing crossover claims only.
- Submit a written description of an acceptable utilization review plan currently in effect.

The effective date of enrollment cannot be earlier than the Medicare certification dates.

Participating out-of-state (border) hospitals are subject to all program regulations and procedures that apply to participating Alabama hospitals and must submit copies of their annual certification from CMS, State licensing authority, and other changes regarding certification. "Border" is defined as within 30 miles of the Alabama state line.

Nonparticipating hospitals are those hospitals that have not executed an agreement with Alabama Medicaid covering their program participation, but that provide medically necessary covered out-of-state services. Application by nonparticipating hospitals is made to Gainwell Provider Enrollment, P.O. Box 241685, Montgomery, AL 36124-1685.

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

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Enrollment Policy for Lithotripsy

The facility must submit a separate application to Gainwell Provider Enrollment along with documentation that the lithotripsy machine is FDA approved and a copy of the lease agreement if the machine is leased. A separate National Provider Identifier is not needed.

Enrollment as a Critical Access Hospital

If a hospital is enrolled as a critical access hospital with Medicare, they are allowed to enroll with Alabama Medicaid as an acute care hospital. If the hospital is already enrolled as a provider with Alabama Medicaid they must submit a new enrollment application and will receive a new Medicaid provider number. Alabama Medicaid does not recognize the distinction between acute care hospital and critical access hospital.

Provider-Based Status

Providers must meet Medicare "provider based status determination" criteria in order to bill Medicaid for outpatient or inpatient services provided in an 'off-campus' location. Refer to 42 CFR 413.65 for details on "provider based status determination".

Change of Ownership (CHOW) and Closures

Medicaid will mirror Medicare's Change of Ownership (CHOW) Policy

Procedures Following a Change in Ownership:

Institutions are to notify Medicaid of any CHOW or closure within 30-days of the change or sale. The new owner has an option to accept assignment of the existing Medicaid provider agreement or to reject it as outlined below:

Accept previous Owner's Medicaid Agreement results in:

- Uninterrupted participation in Medicaid
- Uninterrupted Medicaid reimbursement for claims by utilizing the previous owner's Medicaid ID number
- New owner subjected to any liabilities such as overpayments to the previous owner and any adjustment of payments
- The new owner must complete and submit a Change of Ownership form, a new Electronic Funds Transmittal Form (EFT), W-9, and Disclosure Forms. Disclosure forms must be completed for any new owners, officers, directors, agents, managing employees, and shareholders with 5% or more controlling interest. These required forms are located on the Medicaid Agency website at:

  http://medicaid.alabama.gov/content/9.0_Resources/9.4_Forms_Library/9.4.16_Provider_Enrollment_Forms.aspx

- New owner completes the CHOW form instead of completing a new enrollment application.

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Reject previous Owner's Medicaid Agreement results in:

- Interrupted participation in Medicaid
- Contract terminated effective the date of acquisition
- The new owner's Medicaid contract will be effective the date of Medicare compliance
- The effective date for claims reimbursement not being retroactive to the date of acquisition

Acquisition followed by combination into one institution:

- If the previous owner's agreement is **accepted** by the new owner, the acquired institution becomes a remote location or second campus.
- If the previous owner's agreement is **rejected** by the new owner, the second location must undergo a full Medicare survey.

Procedure following a Closure

In the event that a hospital is closed, Gainwell will end date the hospital's contract effective the date of the closure.

Claims Processing following a Closure

Any claims paid for dates of service after the closure will be recouped.

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 Chapter 7, Understanding Your Rights and Responsibilities as a Provider, for general criteria on Medical Necessity/ Medically Necessary Care.

Refer to Appendix A, EPSDT for details on benefit limits for medically necessary services provided as a result of an EPSDT screening referral. An EPSDT-referring provider number is not required on an inpatient claim form (UB-04). The A1 condition code **is** required on all inpatient claims that are EPSDT referred.

This section includes the following:

Section	*Title*	*Topics Covered*
19.2.1	Inpatient Benefits	• Routine 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

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Section	Title	Topics Covered
		• Payment of Inpatient Hospital Services • Utilization Review for Inpatient Hospital Admissions and Concurrent Stays • Adverse Events, Hospital-Acquired Conditions, and Present on Admission Indicators
19.2.2	Post-hospital Extended Care (PEC) Services	• General Information • PEC NPI • Admitting a Recipient to a PEC • Reimbursement for PEC Services
19.2.3	Swing Beds	• General Information • Level of Care for Swing Beds • Benefit Limitations for Swing Beds • Admission and Periodic Review
19.2.4	Billing Medicaid Recipients	Describes conditions under which Medicaid recipients may be billed for services rendered
19.2.5	Outpatient Services	• Outpatient Surgical Services • Injectable Drugs and Administration • Emergency Hospital Services • Outpatient Hemodialysis • Obstetrical Ultrasounds • Inpatient Admission after Outpatient Hospital Services • Outpatient Observation • Outpatient Hyperbaric Oxygen Therapy • Outpatient Lab and Radiology • Outpatient Chemotherapy and Radiation • Outpatient Physical Therapy • Outpatient Sleep Studies • Outpatient Cardiac Rehabilitation • Prior Authorization for Outpatient Service • Payment of Outpatient Hospital Services • Pulse Oximetry Services
19.2.6	Outpatient and Inpatient Tests	Describes program benefits and limitations for tests
19.2.7	Crossover Reimbursement	Provides crossover reimbursement benefit information for inpatient and outpatient services

19.2.1 Inpatient Benefits

This section describes benefits and policy provisions for the following:

Routine Benefits

An inpatient is a person admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. A person is considered an inpatient with the expectation that he will remain overnight and occupy a bed (even if he is later discharged or is transferred to another hospital and does not use a bed overnight.)

The number of days of care billed to Medicaid for inpatient hospital services is always in units of full days. A day begins at midnight and ends 24 hours later. The midnight-to-midnight method is used to report days of care for Medicaid recipients even if the hospital uses a different definition of day for statistical or other purposes.

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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.

Newborn Inpatient Benefits

Newborn well-baby nursery charges will be covered by an eligible mother's claim for up to ten days nursery care for each baby if the mother is in the hospital and is otherwise entitled to such coverage. For well-baby charges, revenue codes 170 and 171 are reflected on the mother's claim in conjunction with her inpatient stay for the delivery. The hospital per diem rate includes charges for the mother and newborn. Newborn well-baby care is not separately billable. Nursery charges for "boarder babies", infants with no identified problems or condition whose mothers have been discharged, were never admitted to the hospital, or are not otherwise eligible for Medicaid are not separately billable.

Criteria for Revenue Codes 170/171 - The infant is considered to have received "well baby" care if any of these criteria are met in the absence of more severe conditions:

1. Premature infants greater than 5.5 lbs. (2500) grams and/or greater than 35 weeks who are not sick;
2. Stable infants receiving phototherapy for less than 48 hours duration or while the mother is an inpatient receiving routine postpartum care, such as physiologic jaundice, breast milk jaundice, etc.;
3. Infants on intake and output measurements;
4. Stable infants on intermittent alternative feeding methods, such as gavage, or frequent feedings;
5. Stabilized infants with malformation syndromes that do not require acute intervention;
6. Infants with suspected infection on prophylactic IV antibiotics while the mother is an inpatient;
7. Infants receiving close cardiorespiratory monitoring due to family history of SIDS;
8. Infants in stable condition in isolation;
9. Observation and evaluation of newborns for infectious conditions, neurological conditions, respiratory conditions, etc., and identifying those who require special attention;
10. Oliguria;
11. Stable infants with abnormal skin conditions;
12. Routine screenings, such as blood type, Coombs test, serologic test for syphilis, elevated serum phenylalanine, thyroid function tests, galactosemia, sickle cell, etc.;
13. Complete physical exam of the newborn, including vital signs, observation of skin, head, face, eyes, nose, ears, mouth, neck, vocalization, thorax, lungs, heart and vascular system, abdomen, genitalia, extremities, and back.

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Newborns admitted to accommodations other than the well-baby nursery must be eligible for Medicaid benefits in their own right (claim must be billed under the baby's own name and Medicaid number). Example: If an infant is admitted to an intensive care or other specialty care nursery, the claim must be billed under the infant's number even if the mother is still an inpatient.

NOTE:

When billing for multiple births, list each baby's accommodation separately, noting "Baby A," "Baby B," and so on. Also, use the diagnosis codes that indicate multiple live births. For multiple births, nursery days equals the sum of the number of infants times the number of the mother's days.

Effective October 21, 2015, claims can be filed electronically using appropriate multiple birth diagnosis codes.

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

To bill Medicaid utilizing revenue codes 172 (Nursery/Continuing Care), 173 (Nursery/Intermediate Care), 174 (Nursery Intensive Care), and 179 (Nursery/Other), the infant must meet the following criteria established by Medicaid.

Criteria for Revenue Codes 172/173 - The infant must be 36 weeks gestation or less, or 5.5 lbs. (2500 grams) or less, AND have at least one of the following conditions which would cause the infant to be unstable as confirmed by abnormal vital signs or lab values:

1. Respiratory distress requiring significant intervention, including asphyxia and anoxia, or those requiring oxygen for three or more continuous hours, apnea beds, chest tubes, etc.
2. Any nutritional disturbances, intestinal problems or known necrotizing entercolitis;
3. Cardiac disease requiring acute intervention;
4. Neonatal seizures;
5. Conditions which require IV intervention for reasons other than prophylaxis;
6. Apgar scores of less than six at five minutes of age;
7. Subdural and cerebral hemorrhage or other hemorrhage caused by prematurity or low birthweight;
8. Hyperbilirubinemia requiring exchange transfusion, phototherapy or other treatment for acute conditions present with hyperbilirubinemia, such as acidosis, low albumin levels, kernicterus, erythroblastosis, isoimmunization, etc.;
9. Pulmonary immaturity and/or without a pliable thorax, causing hypoventilation and hypoxia with respiratory and metabolic acidosis.

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Criteria for Revenue Code 174 – Services must be provided in a neonatal intensive care unit due to the infant's unstable condition as confirmed by abnormal vital signs or lab values AND at least one of the following conditions:

1. Confirmed sepsis, pneumonia, meningitis;
2. Respiratory problems requiring significant intervention, such as asphyxia and anoxia, or those requiring oxygen for three or more continuous hours, apnea beds, chest tubes, etc.;
3. Seizures;
4. Cardiac disease requiring acute intervention;
5. Infants of diabetic mothers that require IV glucose therapy;
6. Congenital abnormalities that require acute intervention;
7. Total parental nutrition (TPN) requirements;
8. Specified maternal conditions affecting fetus or newborn, such as noxious substances, alcohol, narcotics, etc., causing life threatening or unstable conditions which require treatment;
9. IV infusions which are not prophylactic, such as dopamine, isoproterenol, epinephrine, nitroglycerine, lidocaine, etc.
10. Dialysis;
11. Umbilical or other arterial line or central venous line insertion;
12. Continuous monitoring due to an identified condition;
13. Cytomegalalovirus, hepatitis, herpes simplex, rubella, toxoplasmosis, syphilis, tuberculosis, or other congenital infections causing life threatening infections of the perinatal period;
14. Fetal or neonatal hemorrhage;
15. Hyperbilirubinemia requiring exchange transfusion or other treatment for acute conditions present, such as acidosis, low albumin levels, kernicterus, erythroblastosis, isoimmunization, etc.;
16. Necrotizing enterocolitis, diaphragmatic hernia, omphalocele.

Criteria for Revenue Code 179 – The infant must be unstable as confirmed by abnormal vital signs or lab values AND have one of the following conditions:

1. Close observation after operative procedures;
2. Total parenteral nutrition (TPN);
3. Umbilical or other arterial line or central venous line insertion;
4. Cardiac disease requiring acute intervention;
5. Neonatal seizures;
6. Neonatal sepsis, erythroblastosis, RH sensitization or other causes, or jaundice, requiring an exchange transfusion;
7. Respiratory distress, oxygen requirements for three or more continuous hours, apnea beds, chest tubes, etc.;

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8. IV therapy for unstable conditions or known infection;
9. Any critically ill infant requiring 1:1 monitoring or greater may be maintained on a short-term basis pending transfer to a Level III nursery;
10. Apgar scores of less than six at five minutes of age;
11. Congenital anomalies requiring special equipment, testing, or evaluation;
12. Bleeding disorders;
13. Hyperbilirubinemia of a level of 12 or greater requiring treatment.
14. Hyperbilirubinemia requiring exchange transfusion or other treatment for acute conditions present, such as acidosis, low albumin levels, kernicterus, erythroblastosis, isoimmunization, etc.

These charges are to be billed on a separate UB-04 claim form. ICD-9 or ICD-10-CM diagnosis codes identifying the conditions that required the higher level of care must be on the claim. Medicaid will routinely monitor the coding of neonatal intensive care claims through post-payment review.

Bed and Board in Semi-Private Accommodations

Medicaid pays for semi-private accommodations (two-, three-, or four-bed accommodations). When accommodations more expensive than semi-private are furnished the patient because less expensive accommodations are not available at the time of admission or because the hospital has only private accommodations, Medicaid pays for the semi-private accommodations. In this case, the patient is not required to pay the difference.

When accommodations more expensive than semi-private are furnished the patient at his request, the hospital may charge the patient no more than the difference between the customary charge for semi-private accommodations and the more expensive accommodations at the time of admission. The hospital must have the patient sign a form requesting the more expensive accommodation and agreeing to pay the difference. This form must remain on file for review if questions arise regarding payment of private room charges.

Accommodations other than semi-private are governed by the following rules for private rooms.

Medically Necessary Private Rooms

Payment may be made for a private room or for other accommodations more expensive than semi-private only when such accommodations are medically necessary. Private rooms are considered medically necessary when the patient's condition requires him to be isolated for his own health or for that of others. Isolation may apply when treating a number of physical or mental conditions. Communicable diseases may require isolation of the patient for certain periods. Privacy may also be necessary for patients whose symptoms or treatments are likely to alarm or disturb others in the same room. Medicaid pays for the use of intensive care facilities where medically necessary.

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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.

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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.

Letters of approval or denial will be sent to the requesting provider by Medicaid's coordinating entity upon completion of review by both the appropriate Medicaid Transplant Consultant and Medicaid's Medical Director.

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

Coordination services begin at initial evaluation and continue through a five-year post-operative period. Medicaid covers the following organ transplants for any age:

- Bone marrow transplants
- Kidney transplants
- Heart transplants
- Lung transplants (single or double)
- Heart/Lung transplants
- Liver transplants
- Liver/Small Bowel
- Small Bowel
- Pancreas
- Pancreas/Kidney
- Liver/Pancreas/Small Bowel

For Medicaid-eligible children through the age of 20, EPSDT-referred transplants not listed above will be considered for approval if the transplant is medically necessary, therapeutically proven effective, and considered non-experimental.

Reimbursement for all prior authorized transplants will be an all-inclusive global payment. This global payment includes pre-transplant evaluation; organ procurement; hospital room, board, and all ancillary costs both in and out of the hospital setting; inpatient postoperative care; and all professional fees. All services, room, board, pharmacy, laboratory, and other hospital costs are included under the global payment. All charges for services provided after the discharge, such as patient services, drugs, professional services, and other services will be reimbursed as fee-for-service.

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The global payment represents payment in full. Any monies paid outside the global payment will be recouped. The recipient cannot be billed for the difference between the submitted amount and what the contractor pays.

For transplants performed at another in-state facility or at an out-of-state facility, the contractor negotiates the reimbursement rate with the facility and is responsible for global payment of the transplant from evaluation through hospital discharge. Medicaid reimburses the prime contractor for services provided.

The global payment for covered transplants performed out of state will be inclusive of all services provided out of state for the transplant, including all follow-up care, medications, transportation, food and lodging for caretaker/guardian of minor (if applicable), and home health. Once the patient has been discharged back to Alabama after transplant, services will be reimbursed fee for service and will count against applicable benefit limits.

Medicaid reimbursement is available only to the extent that other third party payers do not cover these services.

For further information regarding the Transplant Program please call the Provider Assistance Center at (800) 688-7989.

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.

Long Acting Reversible Contraception (LARC)

Effective for dates of service June 3, 2019, and thereafter, the Alabama Medicaid Agency (Medicaid) will reimburse the cost of long-acting reversible contraceptives to the facility when provided in the inpatient hospital setting ***immediately*** after a delivery or up to the time of the inpatient discharge for postpartum women, or in the outpatient setting ***immediately*** after discharge from the inpatient hospital for postpartum women.

What steps are necessary for the hospital to receive reimbursement for LARC services when provided in the inpatient setting?

1. The hospital must submit a UB04 claim (bill type 111) to Medicaid for inpatient delivery services with an International Classification of Diseases, Tenth Edition (ICD–10) delivery diagnosis code within the range O00.0 – O9A.53 and one of the following ICD–10 surgical codes for insertion of the device:
    - 0UH97HZ
    - 0UH98HZ
    - 0UHC8HZ

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NOTE:

Note for the delivery claim: Submit prior to the LARC claim and do not include a LARC code.

2. The hospital must submit a **separate** UB-04 claim (bill type 131) to Medicaid with one of the following Healthcare Common Procedure Coding System (HCPCS) codes with the appropriate National Drug Code (NDC) to receive reimbursement for the LARC:
    - J7296 — Kyleena®
    - J7297 — Liletta®
    - J7298 — Mirena®
    - J7300 — Paragard®
    - J7301 — Skyla®
    - J7307 — Nexplanon®

NOTE:

Note for the LARC claim: **Do not submit prior to the delivery claim** and do not include and insertion code. IN addition, the date of service for this claim should be for the actual date of insertion and must overlap the submitted dates of services for delivery.

What steps are necessary for the hospital to receive reimbursement for LARC services when provided in the outpatient setting?

1. The hospital must submit a UB04 claim (bill type 131) to Medicaid.

2. The hospital must use one of the following insertion Common Procedural Terminology (CPT) codes:
    - 58300 — Insertion of IUD
    - 11981 — Insertion, non-biodegradable drug delivery implant (must add ‘FP’ modifier)
    - 11983 — Removal with reinsertion, non-biodegradable drug delivery implant (must add ‘FP’ modifier)

3. The hospital must use one of the following ICD-10 codes:
    - Z30.018 — Encounter for initial prescription of other contraceptives
    - Z30.430 — Encounter for insertion of intrauterine contraceptive device
    - Z30.49 — Encounter for surveillance of other contraceptives

4. The hospital must use one of the following HCPCS codes with the appropriate NDC to receive reimbursement for LARC:
    - J7296 — Kyleena®
    - J7297 — Liletta®
    - J7298 — Mirena®
    - J7300 — Paragard®
    - J7301 — Skyla®
    - J7307 — Nexplanon®

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What steps are necessary for the physician to receive reimbursement for LARC services provided in the inpatient or outpatient hospital setting?

1. The physician must submit a CMS 1500 claim form to Medicaid.

2. The physician must use one of the following insertion CPT codes:
    - 58300 — Insertion IUD
    - 11981 — Insertion, non-biodegradable drug delivery implant (must add 'FP' modifier)
    - 11983 — Removal with reinsertion, non-biodegradable drug delivery implant (must add 'FP' modifier)

3. The physician must use one of the following ICD-10 codes:
    - Z30.018 — Encounter for initial prescription of other contraceptives
    - Z30.430 — Encounter for insertion of intrauterine contraceptive device
    - Z30.49 — Encounter for surveillance of other contraceptives

4. The physician must indicate the place of service as one of the following:
    - 21 — Inpatient hospital setting
    - 22 — Outpatient hospital setting

NOTE:

The Alabama Medicaid Agency covers permanent sterilization only if the recipient has signed a consent form at least 30 days before the procedure is performed.

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 Gainwell. This documentation must meet the criteria set forth under the sterilization and hysterectomy regulations. See Chapter 28, Physician and Chapter 40, Alabama Coordinated Health Network for further details.

NOTE:

Please refer to Section 5.7, Attachments, for information on billing electronic claims with attachments.

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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 and pregnant Medicaid eligible individuals over age 21. See Chapter 13, Dentist, for details.

Payment for Inpatient Hospital Services

Deleted: ~~NOTE: All inpatient…date of service.~~

Refer to the *Alabama Medicaid Administrative Code, Chapter 23, Hospital Reimbursement* for details on current hospital payment methodology.

Repeat Inpatient Admission

When a recipient is discharged and admitted to the same hospital on the same date of service, the hospital should completely discharge the recipient and then readmit on separate UB-04's (even if the readmission was for the same diagnosis).

Inpatient Services for Non-Citizens

- Sterilization codes are non-covered for non-citizens.
- Miscarriages are not currently billable electronically. Requests concerning miscarriages for aliens who are not eligible for pregnancy or full coverage Medicaid must be processed manually. Aliens, who had miscarriages, must continue to present bills timely (within three months) to the SOBRA worker, who determines eligibility; then forwards information to the Central Office for manual processing. Providers will receive a check from Medicaid for miscarriages as well as other alien services approved for reimbursement.
- Delivery Services must be billed through Gainwell for Non-Citizens.
- For UB-04 inpatient claims, the following per diem is covered: Up to 2 days per diem for vaginal delivery and up to 4 days per diem for C-section delivery.
- Allowable diagnosis codes for UB-04 are:
    - For ICD-9
        - V270-V279
        - V300-V3921
        - 65100-65993
        - 6571-6573.
    - For ICD-10
        - Z37.0-Z37.4
        - Z37.50-Z37.54

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- Z37.59
- Z37.60-Z37.64
- Z37.69
- Z37.7
- Z37.9
- Z38.00-Z38.5
- Z38.61-Z38.69
- Z38.7-Z38.8
- O09.40-O09.529
- O30.001-O36.93X9
- O40.1XX0-O43.93
- O61.0-O61.9
- O64.1XX0-O64.9XX9
- O65.0-O66.6
- O68
- O75.2-O75.3
- O75.5
- O75.89-O75.9
- O76-O77.9

- Allowable surgical codes for UB-04 are;
  - For ICD-**9**
    - 740-7499.
  - For ICD-10
    - 10A00ZZ-10A04ZZ
    - 10D00Z0-10D00Z2
    - 10T20ZZ-10T24ZZ

Inpatient Non-covered Services

Medicaid does not cover the following items and services:

- Free items and services for which there is no legal obligation to pay are excluded from coverage, (for example, chest x-rays provided without charge by health organizations).
- Items and services that are required as a result of an act of war, occurring after the effective date of the patient's current coverage are not covered.
- Personal comfort items that do not contribute meaningfully to the treatment of an illness or injury or to functioning of a malformed body

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member are not covered. Charges for special items such as radio, telephone, television, and beauty and barber services are not covered.

- Routine physical check-ups required by third parties, such as insurance companies, business establishments or other government agencies are not covered.
- Braces, orthopedic shoes, corrective shoes, or other supportive devices for the feet are not covered.
- Custodial care and sitters are not covered.
- Cosmetic surgery or expenses in connection with such surgery are not covered. Cosmetic surgery includes any surgical procedure directed at improving appearance, except when required for the prompt repair of accidental injury or for the improvement of the function of a malformed body member. For example, this exclusion does not apply to surgery in connection with treatment of severe burns or repair of the face following a serious automobile accident, nor to surgery for therapeutic service, that coincidentally also serves some cosmetic purpose.
- Items and services to the extent that payment has been made, or can reasonably be expected to be made under a Workman's Compensation Law, a plan of the United States, or a state plan may not be paid for by Medicaid.
- Inpatient hospitalization for routine diagnostic evaluations that could be satisfactorily performed in the outpatient department of the hospital, in a physician's office, or in an appropriate clinic, are not covered.
- Medicaid does not cover psychological evaluations and testing, or psychiatric evaluations, unless actually performed by a psychiatrist in person.
- Medicaid does not cover speech therapy unless actually performed by a physician in person.
- There is no provision under Medicaid for payment of reserved inpatient hospital beds for patients on a pass for a day or more.
- Inpatient services provided specifically for a procedure that requires prior approval is not covered unless prior authorization from Medicaid for the procedure has been obtained by the recipient's attending physician. In the event that the recipient is receiving other services that require inpatient care at the time the procedure is performed, any charges directly related to the procedure will be noncovered and subject to recoupment. Additionally, all admissions must meet Alabama Medicaid Adult and Pediatric (SI/IS) Inpatient Care criteria.

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Utilization Review for Inpatient Hospital Admissions and Concurrent Stays

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

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

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

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

Provider Preventable Conditions (PPCs)

Provider Preventable Conditions (PPCs) are clearly defined into two separate categories: Healthcare Acquired Conditions and Other Provider Preventable Conditions (OPPC's).

Healthcare Acquired Conditions include Hospital Acquired Conditions (HAC's).

Other Provider Preventable Conditions refer to OPPCs (surgery on a wrong body part, wrong surgery on a patient, surgery on a wrong patient).

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

To be reportable, these events must meet the following criteria:

- The PPC must be reasonably preventable as determined by a root cause analysis or some other means.

- The PPC must be within the control of the hospital.

- The PPC must be clearly and unambiguously the result of a preventable mistake made and hospital procedures not followed, and not an event that could otherwise occur.

- The PPC must result in significant harm. The OPPCs for consideration should be limited to those that yield a serious adverse result. Serious adverse result is defined as one that results in death, a serious disability or a substantial increase in the duration and/or complexity of care that is well beyond the norm for treatment of the presenting condition. A serious disability is defined as a major loss of function that endures for more than

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30 days, is not present at the time services were sought and is not related to the presenting condition.

- Any process for identifying non-payable events must actively incorporate some element of case-by-case review and determination. While the source and cause of some may be clear, most would require further investigation and an internal root cause analysis to determine the cause of the serious preventable event and to assign ultimate accountability.

Pursuant to these guidelines, hospitals will not seek payments for additional days directly resulting from PPCs.

Reporting Other Provider-Preventable Conditions (OPPCs)

The following OPPC policy applies to inpatient and outpatient hospitals.

OPPCs must be reported to Medicaid by encrypted emailing of the required information to:

AdverseEvents@medicaid.alabama.gov.. Each hospital will receive a password specifically for e-mail reporting. Reportable "OPPCs" include, but are not limited to:

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

Reports will require the following information: Recipient first and last name, date of birth, Medicaid number, date event occurred and event type. A sample form is on the Alabama Medicaid Agency website at www.medicaid.alabama.gov although hospitals may submit their own form as long as it contains all required information.

NOTE:

***Reporting is required only when not filing a UB-04 claim.**

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

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

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Hospitals should use the POA indicator on claims for these. HACs as identified by Medicare other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients. If no claim is submitted for the event or the event cannot be filed on a UB-04 claim form, then the Alabama Medicaid Agency is to be notified via encrypted e-mail at AdverseEvents@medicaid.alabama.gov . The following information will be required: Recipient first and last name, date of birth, Medicaid number, date of event occurrence and event type. A sample form can be found on the Alabama Medicaid Agency website or a hospital may submit their own form as long as it contains all of the required information. Below are Hospital Acquired Conditions (HACs) with ICD-9 and ICD-10 Codes that hospitals are required to report on the UB-04 claim form.

Selected HAC	CC/MCC (ICD-9-CM Codes)	CC/MCC (ICD-10-CM Codes)
Foreign Object Retained After Surgery	998.4 (CC) and 998.7 (CC)	T81.500A to T81.599A T81.60XA to T81.69XA
Air Embolism	999.1 (MCC)	T80.0XXA
Blood Incompatibility	999.60 (CC) 999.61 (CC) 999.62 (CC) 999.63 (CC) 999.69 (CC)	T80.30XA T80.319A T80.310A T80.311A T80.39XA
Pressure Ulcer Stages III & IV	707.23 (MCC) and 707.24 (MCC)	L89.003 to L89.93 L89.004 to L89.94
Falls and Trauma: -Fracture -Dislocation -Intracranial Injury -Crushing Injury -Burn -Electric Shock	Codes within these ranges on the CC/MCC list: 800-829 830-839 850-854 925-929 940-949 991-994	S02.0XXA to T07 S03.0XXA to S91.109A S06.0X0A to S01.90XA S07.0XXA to S77.20XA T26.50XA to T32.99 T33.011A-T70.9XXA See CMS website for complete listing of diagnoses in the code ranges
Catheter-Associated Urinary Tract Infection (UTI)	996.64. Also excludes the following from acting as a CC/MCC: 112.2 (CC), 590.10 (CC), 590.11 (MCC), 590.2 (MCC), 590.3 (CC), 590.80 (CC), 590.81 (CC), 595.0 (CC), 597.0 (CC), 599.0 (CC)	T83.511A T83.518A B37.41 to B37.49 N10 N10 N15.1 N28.84 to N28.86 N11.9 to N13.6 N16 N30.00 and N30.01 N34.0 N39.0
Vascular Catheter-Associated Infection	999.31 (CC), 999.32 (CC), 999.33 (CC)	T80.218A to T80.219A T80.211A T80.212A
Manifestations of poor glycemic control	250.10-250.13 (MCC), 250.20-250.23 (MCC), 251.0 (CC), 249.10-249.11 (MCC), 249.20-249.21 (MCC)	E10.10 to E13.10 E11.00 to E13.01 E15 E08.00 to E13.10 E08.00 to E13.01

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Selected HAC	CC/MCC (ICD-9-CM Codes)	CC/MCC (ICD-10-CM Codes)
Surgical Site Infection, Mediastinitis, Following Coronary Artery Bypass Graft (CABG)	519.2 (MCC) and one of the following procedure codes: 36.10-36.19.	Secondary diagnosis J98.51 or J98.59 See CMS website for listing of associated Procedure Codes
Surgical Site Infection Following Certain Orthopedic Procedures of Spine, Shoulder or Elbow	996.67 (CC) 998.59 (CC) And one of the following procedure codes: 81.01-81.08, 81.23. 81.24 81.31-81.38, 81.83, 81.85	T84.60XA to T84.7XXA K68.11 to T81.4XXA See CMS website for listing of associated Procedure Codes
Surgical Site Infection Following Bariatric Surgery for Obesity	Principal Diagnosis code-278.01, 539.01 (CC), 539.81 (CC) OR 998.59 (CC) and one of the following procedure codes: 44.38,44.39, or 44.95	Principal Diagnosis code E6601 and one of the secondary diagnosis codes: K68.11, K9501, K9581 or T81.4XXA See CMS website for listing of associated Procedure Codes
Surgical Site Infection Following Cardiac Implantable Electronic Device (CIED)	996.61 (CC) or 998.59 (CC) and one of the following procedure codes: 00.50, 00.51, 00.52, 00.53, 00.54, 37.80, 37.81, 37.82, 37.83, 37.85, 37.86, 37.87, 37.94, 37.96, 37.98, 37.74, 37.75, 37.76, 37.77, 37.79, 37.89	K68.11, T814XXA. T826XXA, T827XXA See CMS website for listing of associated Procedure Codes
Deep Vein Thrombosis/ Pulmonary Embolism with total knee or hip replacement	415.11 (MCC), 415.13 (MCC), 415.19 (MCC), or 453.40-453.42 and one of the following procedure codes: 00.85-00.87, 81.51-81.52, or 81.54.	T80.0XXA to T82.818A I26.90, I2699 I26.09, I26.99 I82.401 to I82.4Z9 See CMS website for listing of associated Procedure Codes
Iatrogenic Pneumothorax with Venous Catheterization	512.1 (CC) and the following procedure code: 38.93	J95.811 See CMS website for listing of associated Procedure Codes

For the complete updated list of HAC ICD-10 Diagnosis and Procedure Codes for each HAC category, reference the appropriate FY for the dates of service on the claim. Use the CMS link: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/icd10_hacs.html

For ICD-10, please use the CMS Diagnosis Listing for POA Exempt Diagnosis Codes at: https://www.cms.gov/Medicare/Coding/ICD10/index.html

Select the appropriate fiscal year ICD-10-CM POA Exempt file for the dates of service on the claim. These codes are for recipient encounters occurring between October 1st through September 30th of each fiscal year.

All Diagnosis codes NOT present in the listing require POA indicator.

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

Non-payment of provider preventable conditions shall not prevent access to services for Medicaid beneficiaries.

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

Reductions in Provider payment may be limited to the extent that the following apply:

- The Identified PPC would otherwise result in an increase in payment.
- Hospitals are paid based on a daily per diem rate. It is the responsibility of the hospital to identify any Health Care-Acquired Condition and not seek payment for any additional days that have lengthened a recipient's stay due to a PPC. In reducing the amount of days: Hospitals are to report a value code of '81' on the UB-04 claim form along with any non-covered days and the amount field must be greater than '0'.

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

- **Y**-Yes. Diagnosis was present at time of inpatient admission.
- **N**-No. Diagnosis was not present at time of inpatient admission.
- **U**-No information in the record. Documentation insufficient to determine if the condition was present at the time of inpatient admission.
- **W**-Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission.

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

A document with frequently asked questions has been posted on the Agency's website under Programs/Hospital Services.

19.2.2 Post Extended Care (PEC) Services

General Information

Inpatient hospital services rendered at a level of care lower than acute are considered post extended care services (PEC). The patient must have received a minimum of three consecutive days of acute care services in the

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hospital requesting PEC reimbursement. Intra-facility transfers will not be authorized for reimbursement as PEC services. These services include care ordinarily provided by a nursing facility. Refer to Chapter 26, Nursing Facilities, for details.

Medically necessary services include, but are not limited to the following:

- Nursing care provided by or under the supervision of a registered nurse on a 24-hour basis
- Bed and board in a semi-private room; private accommodations may be used if the patient's condition requires isolation, if the facility has no ward or semi-private rooms, or if all ward or semi-private rooms are full at the time of admission and remain so during the recipient's stay
- Medically necessary over-the-counter (non-legend) drug products ordered by physician (Generic brands are required unless brand name is specified in writing by the attending physician)
- Personal services and supplies ordinarily furnished by a nursing facility for the comfort and cleanliness of the patient
- Nursing and treatment supplies as ordered by the patient's physician or as required for quality nursing care. These include needles, syringes, catheters, catheter trays, drainage bags, indwelling catheters, enema bags, normal dressing, special dressings (such as ABD pads and pressure dressings), intravenous administration sets, and normal intravenous fluids (such as glucose, D5W, D10W, and normal saline)
- Services ordinarily furnished to an inpatient of a hospital

PEC National Provider Identifier

In order to receive reimbursement for PEC, the hospital must have a NPI. The NPI allows the hospital to designate up to ten beds for these services for hospitals with up to 100 beds, and an additional ten beds per each 100 beds thereafter. **All PEC services must be billed using a 'PEC' NPI.**

Determining the Availability of Nursing Facility Beds

Prior to the hospital admitting a patient to one of these beds, the hospital must first determine that there is no nursing facility bed available within a reasonable proximity and that the recipient requires two of the following medically necessary services on a regular basis:

- Administration of a potent and dangerous injectable medication and intravenous medications and solutions on a daily basis
- Restorative nursing procedures (such as gait training and bowel and bladder training) in the case of residents who are determined to have restorative potential and can benefit from the training on a daily basis
- Nasopharyngeal aspiration required for the maintenance of a clear airway
- Maintenance of tracheostomy, gastrostomy, colostomy, ileostomy, or other tubes indwelling in body cavities as an adjunct to active treatment for rehabilitation of disease for which the stoma was created
- Administration of tube feedings by naso-gastric tube

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- Care of extensive decubitus ulcers or other widespread skin disorders
- Observation of unstable medical conditions required on a regular and continuing basis that can only be provided by or under the direction of a registered nurse
- Use of oxygen on a regular or continuing basis
- Application of dressing involving prescription medications and aseptic techniques and/or changing of dressing in non-infected, post-operative, or chronic conditions
- Routine medical treatment for a comatose patient

Admission and Periodic Review for PECs

To establish medical necessity, an application packet must be submitted to Medicaid within 60 days from the date Medicaid coverage is requested. The 60 days are calculated from the date the application is received and date stamped. All applications with a date over 60 days old will be assigned an effective date that is 60 days prior to the date stamp. No payment will be made for the days prior to the assigned effective date. The facility will be informed in writing of the assigned effective date.

The application packet consists of the following:

- A fully completed Medicaid Status Notification form XIX-LTC-4 including documentation certified by the applicant's attending physician to support the need for nursing home care
- Documentation certifying the patient has received inpatient acute care services for no less than three consecutive days during the current hospitalization in the requesting hospital prior to the commencement of post-extended care services. These days must have met the Medicaid Agency's approved acute care criteria
- Documentation certifying contact was made with each nursing facility within a reasonable proximity to determine bed non-availability prior to or on the date coverage is sought, and every 15 days thereafter

In order to continue PEC eligibility, re-certification must be made every 30 days. Nursing facility bed non-availability must be forwarded along with request for re-certification.

Reimbursement for PEC Services

Reimbursement for PEC services is made on a per diem basis at the average unweighted per diem rate paid by Medicaid to nursing facilities for routine nursing facility services furnished during the previous fiscal year. There shall be no separate year-end cost settlement. Refer to the *Alabama Medicaid Agency Administrative Code,* Chapter 22, for details on rate computation.

A provider must accept the amount paid by Medicaid plus any patient liability amount to be paid by the recipient as payment in full, and further agrees to make no additional charge or charges for covered services.

Any day a patient receives such PEC services is considered an acute care inpatient hospital day. These beds are not considered nursing facility beds.

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All PEC services must be billed using the PEC NPI with the exception of outpatient services, pharmaceutical items to include over-the counter products, and prescription drugs.

- Outpatient services such as lab and x-ray services should be billed under the hospital National Provider Identifier number.
- Pharmaceutical items, to include over-the-counter products and prescription drugs should be billed separately under the hospital's pharmacy National Provider Identifier number.
- A Medicaid pharmacy provider outside of the hospital may fill the prescriptions if the hospital pharmacy is not a Medicaid provider.

19.2.3 Swing Beds

General Information

Swing beds are hospital beds that can be used for either skilled nursing facility (SNF) or hospital acute care levels of care on an as needed basis if the hospital has obtained a swing bed approval from the Department of Health and Human Services.

Swing bed hospitals must meet all of the following criteria:

- Have fewer than 100 beds (excluding newborn and intensive care beds) and be located in a rural area as defined by the Census Bureau based on the most recent census
- Be Medicare certified as a swing bed provider
- Have a certificate of need for swing beds
- Be substantially in compliance with SNF conditions of participation for patient rights, specialized rehabilitation services, dental services, social services, patient activities, and discharge planning. (Most other SNF conditions would be met by virtue of the facilities compliance with comparable conditions of participation for hospitals.)
- Must not have in effect a 24 hour nursing waiver
- Must not have had a swing bed approval terminated within the two years previous to application for swing bed participation

NOTE
Swing Bed hospital enrollment is limited to in-state hospital providers only

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.

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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 Medical and Quality Review Unit or designee will perform admission review of all Medicaid admissions to assure the necessity and appropriateness of the admission and that a physician has certified on the date of admission, the need for swing bed care. Medicaid or its designee certifies the level of care required by the patient at the time of admission using Form 199.

For applications which are not approved by the Medical and Quality review Unit or its designee, a Medical Director, will review and either approve or deny the medical eligibility.

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 all doctor’s orders, progress and nurses’ notes for the time in question to Medicaid’s fiscal agent. Attach all doctors' orders, progress and nurses' notes for the time in question.

Medical approvals may be issued by the Medicaid Medical and quality Review Unit or designee if the information provided to Medicaid documents the need for SNF care and the recipient meets criteria set forth in Rule 560-X-10-.10 of Medicaid’s Administrative Code, for SNF care.

The admission application packet must be sent to the Medicaid Medical and Quality Review unit or designee within 60 days from the date Medicaid coverage is sought and must consist of a fully completed Medicaid Status Notification Form 199 including all documentation certified by the applicant’s attending physician to support the need for nursing home level of care.

Once the Form 199 has been reviewed and approved medically, the facility is notified by a letter advising that the patient is medically eligible for swing bed services.

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.

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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.

Reimbursement requires a 3-day qualifying stay in any acute care hospital prior to admission to a swing bed in any hospital. The swing bed stay must fall within the same spell of illness as the qualifying stay.

Electronic Upload and Submission of Medical Records

Swing bed records for approval may be uploaded two different ways:

- Medicaid Interactive Web Portal (preferred)
- https://www.medicaid.alabamaservices.org/ALPortal/Account/Secure%20-Site/tabId/66/Default.aspx
- Fax information in for processing (bar coded cover sheet required)

Documents must be in a Portable Document Format (PDF) for upload through the Medicaid web portal. If you do not currently have the ability to create PDF versions of medical records, you may perform an internet search and find free downloadable utilities that can be installed to create a PDF. For your convenience, a list of three PDF creation utilities that can be installed to create PDF documents at no charge.

- PrimoPDF – http://www.primopdf.com/
- Solid PDF Creator - http://www.freepdfcreator.org/
- PDF24 – http://pdf24-pdf-creator.en.softonic.com/

Once a PDF utility has been successfully downloaded and the PDF document created, providers should follow these steps to upload documentation for review:

1. Log on to Medical Interactive Web portal:

   https://www.medicaid.alabamaservices.org/ALPortal/Account/Secure%20-Site/tabId/66/Default.aspx

2. Select Trade Files/Forms.

Forms Name field – select LTC – PEC/Swing Bed Records from the drop down list and click on “Search”.

3. Complete all fields (record ID field will auto populate). Required
4. Click on ‘Browse’ and select the required medical records documentation from your network drive or PC and select ‘Submit’.
5. A message will be generated that states ‘your form was submitted successfully’ at the top of the page.
6. A barcode coversheet is generated and will be displayed.
7. Select the ‘Print Friendly View’ button to print the barcode coversheet or to save as a PDF. A copy of this barcode coversheet should be saved in the event additional documentation is required.

If a PDF document of the medical records cannot be created, information may also be faxed for review. A fax cover sheet will be required with each

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submission; providers should follow the instructions below to fax documentation:

1. Follow steps 1-7 documented above.
2. Fax the required medical records documentation with the barcode coversheet on top of the documentation to 334-215-7416.Include the bar coded cover sheet with each submission for the same recipient.
3. Do not fax double sided pages.
4. Do not fax multiple sets of records at the same time, each fax should be sent separately.

NOTE:

The bar code cover sheet is required for each fax submission for the same recipient. A fax submission cannot be processed without the bar coded cover sheet. DO NOT place anything on the bar code on the cover sheet or alter it any manner.

19.2.4 Billing Medicaid Recipients

Providers may bill recipients for non-covered services, for example, days that do not meet the Alabama Medicaid Adult and Pediatric Inpatient Care Criteria. private room accommodation charges incurred due to patient's request, or personal comfort items.

The provider is responsible for informing the recipient of non-covered services. Medicaid recipients in hospitals may be billed for non-covered inpatient care occurring **after** they have received written notification of Medicaid non-coverage of hospital services. If the notice is issued prior to the recipient's admission, the recipient is liable for full payment if he enters the hospital. If the notice is issued at or after admission, the recipient is responsible for payment for all services provided **after** receipt of the notice.

19.2.5 Outpatient Hospital Services

Outpatient hospital services include preventive, diagnostic, therapeutic, rehabilitative, or palliative services provided to an outpatient by or under the direction of a physician or dentist at a licensed hospital. Medical services provided in an outpatient setting must be identified and the specific treatment must be documented in the medical record. Outpatient visits (99281, 99282, 99283, 99284 and 99285) are unlimited.

Outpatient Surgical Services

Outpatient surgical services are those covered procedures commonly performed on an inpatient basis that may be safely performed on an outpatient basis. Only those surgeries included on the Medicaid outpatient hospital fee schedule will be covered on an outpatient basis. Surgeries included on the Medicaid outpatient surgical list are reimbursable when provided on an inpatient basis if utilization review criteria are met. Hospitals may bill other procedures (within the 90000 range) if they are listed on the Outpatient Fee Schedule located on the Medicaid website: www.medicaid.alabama.gov . Providers should refer to the fee schedule before scheduling outpatient surgeries since some procedures are restricted to recipients under age 20 and others may require prior authorization.

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Surgical procedures that are not listed on Medicaid's outpatient fee schedule may be sent to the Institutional Services Unit to be considered for coverage in the outpatient setting if medically necessary and the procedure is approved by the Medical Director. Refer to the Hospital Fee Schedule on the Medicaid website for a list of covered surgical codes.

Patients who remain overnight after outpatient surgery, will be considered as an outpatient UNLESS the attending physician has written orders admitting the recipient to an inpatient bed. In such instances all outpatient charges should be combined on the inpatient claim.

NOTE:

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

Lab and x-ray not directly related to the surgical procedure are not included in the fee and may be billed in addition to the surgical procedures that are reimbursed. Surgery procedure codes are billed with units of one.

Any lab and x-ray procedures considered 'directly related' to the surgical procedure are part of the reimbursement for the surgical fee if performed within 3 days (or 72 hours) prior to the surgery.

Any lab and x-ray procedures done as a pre-op for surgery will be covered by Medicaid in instances where the recipient is a 'no-show' for a scheduled surgical procedure.

In instances where a surgical procedure code has not been established or is an unlisted code the provider may bill the most descriptive procedure code with modifier 22 (unusual procedural services) until a covered procedure code is established.

Outpatient surgery reimbursement is a fee-for-service rate established for each covered surgical procedure on the Medicaid outpatient surgical list. This rate is established as a facility fee for the hospital and includes the following:

- All nursing and technician services
- Diagnostic, therapeutic and pathology services
- Pre-op and post-op lab and x-ray services
- Materials for anesthesia
- Drugs and biologicals
- Dressings, splints, casts, appliances, and equipment directly related to the surgical procedure.

In order to bill for bilateral procedures (previously identified by modifier 50), the most appropriate procedure code must be billed on two separate lines and appended by the most appropriate anatomical modifier (i.e. RT, LT, etc.).

Medicaid will automatically pay the surgical procedure code with the highest reimbursement rate at 100% of the allowed amount and the subsequent surgical procedures at 50%, minus TPL and copay.

Providers may visit the Medicaid website: www.medicaid.alabama.gov. Click on Providers/Fee Schedules. Select "Outpatient Fee Schedule" from the list

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of available schedules, or continue to use the AVRS line at Gainwell (1 (800) 727-7848) to verify coverage.

NOTE:

Procedures not listed in in the Ambulatory Surgical Center fee schedule or the Outpatient Fee Schedule may be covered for special circumstances. Approval must be obtained prior to the surgery. Refer to Chapter 4, Obtaining Prior Authorization. Providers should inform recipients prior to the provision of services as to their responsibilities for payment of services not covered by Medicaid.

Injectable Drugs and Administration

Medicaid has adopted Medicare's Drug Pricing Methodology utilizing the Average Sale Price (ASP) for HCPCS injectable drug codes. Hospitals are required to bill the current CPT codes for chemotherapy and non-chemotherapy administration. Please refer to the Alabama Medicaid website at www.medicaid.alabama.gov for a listing of injectable drug codes.

The following CPT drug administration code-ranges will remain as covered services:

- CPT code ranges 96360 through 96375, and CPT code ranges 96401 through 96542.

These guidelines should be followed by hospitals for billing administration codes:

- No administration fee (infusions, injections, or combinations) should be billed in conjunction with an ER visit (99281 – 99285).

- When administering multiple infusions, injections, or combinations, only one "initial" drug administration service code should be reported per patient per day, unless protocol requires that two separate IV sites must be utilized. The initial code is the code that best describes the services the patient is receiving and the additional codes are secondary to the initial one.

- "Subsequent" drug administration codes, or codes that state the code is listed separately in addition to the code for the primary procedure, should be used to report these secondary codes. If an injection or infusion is of a subsequent or concurrent nature, even if it is the first such service within that group of services, then a subsequent or concurrent code from the appropriate section should be reported.

- If the patient has to come back for a separately identifiable service on the same day, or has two IV lines per protocol, these services are considered separately billable with a modifier 76.

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340-B Hospitals

340-B hospitals may bill 'total charges' on the UB-04 claim form when billing for outpatient pharmacy charges.

Hospital-Based Clinics

Effective January 1, 2014, CMS made changes to the CY 2014 Hospital Outpatient prospective payment system for hospital outpatient clinic visits, which the Alabama Medicaid Agency will follow effective for dates of service April 1, 2014, and thereafter.

CMS's policy calls for hospital to bill for all outpatient hospital clinic visits using a single HCPCS code, G0463 (Hospital outpatient clinic visit for assessment and management of a patient), which replaces CPT E&M codes 99201 – 99205 and 99211 – 99215.

Effective **for dates of service April 1, 2014**, and thereafter, HCPCS code G0463 (Hospital Outpatient Clinic Visit for Assessment and Management of a Patient) will replace CPT E&M codes 99201-99205 and 99211-99215 for outpatient hospital-based clinic visits.

For claims **with dates of service through March 31, 2014**, the hospital will continue to bill the CPT E&M codes 99201 – 99205 and 99211 – 99215 for outpatient hospital-based clinic visits.

For claims **with dates of service April 1, 2014**, and thereafter the hospital will bill G0463 for outpatient hospital-based clinic visits.

Effective for dates of service on or after April 1, 2014, Medicaid will allow revenue code 51X, clinic, to be billed with evaluation and management HCPCS code G0463. Only one visit per day will be allowed.

Emergency Hospital Services

Emergency medical services provided in the hospital emergency room must be certified and signed by the attending licensed physician, nurse practitioner or physician assistant 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 Alabama Coordinated Health Network (ACHN) Program, refer to Chapter 40, to determine whether your services require a referral from the Primary Care Physician (PCP).

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 licensed physician, nurse practitioner or physician assistant are the only ones who can certify an emergency visit. In determining whether a claim should be submitted and documented as a certified emergency, consider the following guidelines:

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- 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 licensed physician, nurse practitioner or provider assistant at the time services are rendered. The claim form for a certified emergency must have an “E” in field 73 on the UB-04 claim form.

UB-04 claims for emergency department services must be coded according to the criteria established by Medicaid to be considered for payment.

These procedure codes (99281-99285) may be billed only for services rendered in a hospital emergency department and must be listed on the UB-04 claim form with revenue code 450.

Only one emergency room visit per day per provider will be reimbursed by Medicaid.

Outpatient Hemodialysis

Outpatient dialysis services are covered under the End-Stage Renal Disease Program and cannot be reimbursed as an outpatient hospital service. See Chapter 35, Renal Dialysis Facility, for details.

Obstetrical Ultrasounds

Ultrasound payment is limited to one per day. Effective 10/1/2019, Medicaid no longer requires prior authorization for obstetrical ultrasounds. All ultrasounds must be medically necessary with medical diagnosis documented supporting the benefit of the ultrasound procedure. Delivery Healthcare Professionals (DHCPs) should refer to Chapter 40 for details regarding care coordination.

With supportive documentation, the time limit for filing ultrasound claims may be extended for extenuating circumstances, such as TPL claims, miscarriages not known to providers, and dropouts. In these instances the time limit would revert to the 1 year time limit from date of service.

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Inpatient Admission After Outpatient Hospital Services

If the patient is admitted as an inpatient before midnight of the day the outpatient services were rendered at the same hospital, all services are considered inpatient services for billing purposes. The day of formal admission as an inpatient is considered to be the first day of inpatient hospital services.

Outpatient Observation

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

Outpatient observation is the medically necessary extended outpatient care provided to a patient whose condition warrants additional observation before a decision is made about admission to the hospital or prolonged patient care. Outpatient observation can be billed for a recipient that has been seen in the emergency room or is a maternity recipient whose provider ordered observation services.

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 before a decision is made about admission to the hospital. 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:

- 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.

Outpatient observation charges (99218-99220) must be billed in conjunction with the appropriate facility fee (99281 – 99285), except for those maternity recipients whose provider has ordered observation services.

Observation charges are billed as follows:

- For the first three hours of observation, the provider should bill the appropriate facility fee (99281 - 99285) in units of one, in conjunction with the appropriate Observation charges (99218-99220) in hourly increments. Observation charges are limited to 23 hours.
- For the 4th -23rd hours of Observation, the provider bills procedure code G0378 with the appropriate facility fee (99281-99285) in units of 1.
- For Observation Services that spans midnight, (recipient is discharged from Observation and admitted to the hospital **after** midnight), the provider bills all Observation charges using the admission date to Observation Services, rendering the Per Diem method of payment in effect on the date of admission to Observation Services.

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- For Observation Services that does NOT span midnight, (recipient is discharged from Observation and admitted to the hospital on the same day, **before** midnight), the provider bills all Observation charges with the inpatient charges. In other words, bill for the first 3 hours as noted above and for the 4th -23rd hours (actual hours incurred) as noted above, then bill the Per Diem for each day with inpatient status.

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

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 Hyperbaric Oxygen Therapy (HBO)

Hyperbaric oxygen therapy (HBO) is covered in an outpatient hospital setting under the guidelines listed below. HBO should not be a replacement for other standard successful therapeutic measures. Medical necessity for the use of HBO for more than two months duration must be prior approved. Prior approval (PA) requests for diagnoses not listed below or for treatment exceeding the limitations may be submitted for consideration to the Office of the Associate Medical Director. No approvals will be granted for conditions listed in the exclusion section. HBO should be billed on the UB-04 by the outpatient facility using revenue code 413 and procedure code 99183. Physician attendance should be billed on the CMS-1500 using CPT code 99183.

Physician attendance should be billed on the CMS-1500 using CPT code 99183.

Reimbursement for HBO is limited to that which is administered in a chamber for the following diagnoses:

Air or Gas Embolism

ICD-9: 9580 991
ICD-10: I74.2-I74.5
T79.0XXA-T79.0XXS
T80.0XXA-T80.0XXS
Limited to five treatments per year. required after five treatments.

Acute Carbon Monoxide Poisoning

ICD-9: 986
ICD-10: T58.01XA-T58.94XS
Limited to five treatments per incidence. Treatment should be discontinued when there is no further improvement in cognitive functioning. PA required after five treatments

Decompression Illness

ICD-9: 9932 9933
ICD-10: T70.3XXA-T70.3XXS
Limited to ten treatments per year. Treatment should continue until Clinical exam reveals no further Improvements in response to therapy.

Gas Gangrene

ICD-9: 0400
ICD-10: A48.0
Limited to ten treatments per year. PA required after ten treatments.

Crush Injury

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ICD-9:
92700 92701 92702
92703 92709 92710
92711 92720 92721
9278 9279 92800
92801 92810 92811
92820 92821 9283
9288 9290 9299
99690 99691 99692
99693 99694 99695
99696 99699

ICD-10:
S35.511A-S35.513S
S47.1XXA-S47.9XXS
S57.00XA-S57.82XS
S67.00XA-S67.92XS
S77.00XA-S77.22XS
S87.00XA-S87.82XS
S97.00XA-S97.82XS
T87.0X1-T87.2

Limited to 15 treatments per year. Early application of HBO, preferably within four - six hours of injury, is essential for efficacy. The recommended treatment schedule is three 90 minute treatments per day over the first 48 hours after the injury; followed by two 90 minute treatments per day over the second period of 48 hours; and one 90 minute treatment over the third period of 48 hours.

Chronic Refractory Osteomyelitis
ICD-9: 73010 – 73019
ICD-10: M86.30-M86.8X9

Limited to 40 treatments per year. To be utilized for infection that is persistent or recurring after appropriate interventions.

Diabetic wounds of lower extremities

ICD-9:
70710 70711
70715 70719
70712 70714

ICD-10:
I70.231-I70.25
I70.331-I70.35
I70.431-I70.45
I70.531-I70.55
I70.631-I70.65
I70.731-I70.75
L97.102-L97.109
L97.112-L97.119
L97.122-L97.129
L97.202-L97.209
L97.212-L97.219
L97.202-L97.209
L97.212-L97.219
L97.222-L97.229
L97.302-L97.309
L97.312-L97.319
L97.322-L97.329

Radiation tissue damage

ICD-9:
52689
990

ICD-10:
L59.8
M27.2
M27.8
T66.XXXA

Limited to 60 treatments per year. To be utilized as part of an overall treatment plan, including debridement or resection of viable tissues, specific antibiotic therapy, soft tissue flap reconstruction and bone grafting as may be indicated.

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L97.402-L97.409
L97.412-L97.419
L97.422-L97.429
L97.502-L97.509
L97.512-L97519
L97.522-L97.529
L97.802-L97.809
L97.812-L97.819
L97.822-L97.829
L97.902-L97.909
L97.912-L97.919
L97.922-L97.929
L98.412-L98.419
L98.422-L98.429
L98.492-L98.499
Limited to 30 treatments per year. To be utilized only when wound fails to respond to established medical/surgical management. , Requires an aggressive multidisciplinary approach to optimize the treatment of problem wounds. Diabetic wounds of the lower extremities are covered for patients who have type I or II diabetes and if the wound is classified as Wagner grade III or higher. .

Skin grafts and flaps
ICD-9: 99652
ICD-10: T86.820-T86.829
Limited to 40 treatments per year.
Twenty treatments to prepare graft site and 20 after graft or flap has been replaced.

Progressive necrotizing infection (necrotizing fasciitis)
ICD-9:72886
ICD-10: M726
Limited to 10 treatments per year.
PA required after 10 treatments.

Acute peripheral arterial insufficiency
ICD-9: 44421 44422 44481
ICD-10: I74.2-I74.5
Limited to five treatments per year.
PA required after five treatments.

Acute traumatic peripheral Ischemia
ICD-9: 90253 90301 9031 9040 90441
ICD-10:
S35.511-S35.512
S45.011-S45.019 per incident. PA required after five treatments.
S45.091-S45.092
S45.111-S45.112
S45.191-S45.199
S45.211-S45.219

Cyanide poisoning
ICD-9: 9877 9890
ICD-10:T57.3X1A-T57.3X4A
T65.0X1A-T65.0X4A
Limited to five treatments

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S45.291-S45.299
S75.011-S75.012
S75.021-S75.022
S75.091-S75.099
S85.011-S85.019
S85.091-S85.099
Limited to 15 treatments per year

Actinomycosis
ICD-9:
0390 - 0394
0398 - 0399
ICD-10:
A42.0
A42.1
A42.2
A42.89
A42.9
A43.0
A43.1
A43.8
A43.9
B47.1
B47.9
L08.1
Limited to 10 treatments per year.
PA required after 10 treatments.

Exclusions
No reimbursement will be made for HBO provided in the treatment of the following conditions.

Cutaneous, decubitus, and stasis ulcer
Chronic peripheral vascular insufficiency
Anaerobic septicemia and infection other than clostridial
Skin burns
Senility
Myocardial Infarction
Cardiogenic Shock
Sickle Cell Crisis
Acute thermal and chemical pulmonary damage (i.e., smoke inhalation with pulmonary insufficiency)
Acute or chronic cerebral vascular insufficiency
Hepatic necrosis
Aerobic Septicemia
Nonvascular causes of common brain syndrome (i.e., Pick's disease, Alzheimer's disease, Korsakoff's disease)
Tetanus
Systemic aerobic infection
Organ transplantation
Organ storage
Pulmonary emphysema
Exceptional blood loss anemia
Multiple sclerosis

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Arthritic diseases
Acute cerebral edema

Nerve Conduction Studies and Electromyography

Refer to Chapter 22 of Medicaid's Provider manual for more information on this policy.

Outpatient Lab and Radiology

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 may be span billed for a calendar month. Diagnostic lab, diagnostic x-ray, and blood administration may be span billed in conjunction with outpatient chemotherapy and radiation.

Outpatient Physical Therapy

Physical therapy is a covered service based on medical necessity. Physical therapy is covered in a hospital outpatient setting for acute conditions. Recipients receiving therapy must be under the care of a physician or non-physician practitioner who certifies the recipient's need for therapy.

For all physical therapy services performed as a result of an EPSDT screening refer to Chapter 37, Therapy, for policy only. Outpatient hospital physical therapy services will continue to be limited to those CPT codes listed in this chapter.

If the therapy continues past the 60th day, there must be documentation in the patient's medical record that a physician or non-physician practitioner has recertified the patient within 60 days after the therapy began and every 30 days past the 60th day. Therapy services are not considered medically necessary if this requirement is not met. The 60-day period begins with the therapist's initial encounter with the patient (i.e., day the evaluation was performed). In the event an evaluation is not indicated, the 60-day period begins with the first treatment session. The therapist's first encounter with the patient should occur in a timely manner from the date of the physician's therapy referral.

Documentation in the patient's medical record must confirm that all patients receiving physical therapy services have been seen by the certifying physician as specifically indicated above. Having a physician signature on a certification or re-certification will not meet this requirement.

Rehabilitative services are not covered. Rehabilitative services are the restoration of people with chronic physical or disabling conditions to useful activity.

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Physical therapy services are limited to those CPT codes listed in this chapter. Maximum units for daily and annual limits are noted for each covered service.

Form 384 (Motorized/Power Wheelchair Assessment Form) may be obtained by contacting the Long Term Care Provider Services at 1-800-362-1504, option 1 for providers.

Records are subject to retrospective review. Physical therapy records must state the treatment plan and must meet the medical criteria below. If the medical criteria are not met or the treatment plan is not documented in the medical record, Medicaid may recoup payment.

Medical Criteria for Physical Therapy

Physical therapy is subject to the following criteria:

- Physical therapy is covered for acute conditions only. An acute condition is a new diagnosis that was made within three months of the beginning date of the physical therapy treatments.
- Chronic conditions are not covered except for acute exacerbations or as a result of an EPSDT screening. A chronic condition is a condition that was diagnosed more than three months before the beginning date of the physical therapy treatments. An acute exacerbation is defined as the sudden worsening of the patient's clinical condition, both objectively and subjectively, where physical therapy is expected to improve the patient's clinical condition. For EPSDT recipients with chronic conditions refer to Chapter 37, Therapy, for policy only regarding physical therapy services. Physical therapy services are limited to those CPT codes listed in this chapter.

Plan of Treatment

In addition to the above stated medical criteria, the provider of service is responsible for developing a plan of treatment. This plan of treatment must be readily available at all times for review in the recipient's medical record. The plan of treatment should contain at least the following information:

- Recipient's name
- Recipient's current Medicaid number
- Diagnosis
- Date of onset or the date of the acute exacerbation, if applicable
- Type of surgery performed, if applicable
- Date of surgery, if applicable
- Functional status prior to and after therapy is completed
- Frequency and duration of treatment
- Modalities
- For ulcers, the location, size, and depth should be documented

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The plan of treatment must be signed by the physician who ordered the physical therapy and the therapist who administered the treatments.

Physical Therapy (PT) Assistants

Physical therapy services provided in an outpatient hospital setting must be ordered by a physician and must be provided by or under the supervision of a qualified physical therapist.

Physical therapy assistants must work under the direction of a physical therapist with the following provisions:

- The PT must interpret the physician's referral.
- The PT must perform the initial evaluation.
- The PT must develop the treatment plan and program, including long and short-term goals.
- The PT must identify and document precautions, special problems, contraindications, goals, anticipated progress and plans for reevaluation.
- The PT must reevaluate the patient and adjust the treatment plan, perform the final evaluation and discharge planning.
- The PT must implement (perform the first treatment) and supervise the treatment program.
- The PT must co-sign each treatment note written by the physical therapy assistant.
- The PT must indicate he/she has directed the care of the patient and agrees with the documentation as written by the physical therapy assistant for each treatment note.

The PT must render the hands-on treatment, write and sign the treatment note every sixth visit.

Outpatient Sleep Studies

Sleep studies are covered services in an outpatient hospital. Medicaid does not enroll sleep study clinics. Indications for coverage are as follows:

Polysomnography includes sleep staging that is refined to include a 1-4 lead electroencephalogram (EEG), and electro-oculogram (EOG), and a submental electromyogram (EMG). For a study to be reported as polysmnography, sleep must be recorded and staged for 6 hours and an attendant must be present throughout the course of the study.

The following are required measurements:

- Electrocardiogram (ECG)
- Airflow
- Ventilation and respiratory effort
- Gas exchange by oximetry, transcutaneous monitoring, or end tidal gas analysis
- Extremity muscle activity, motor activity-movement

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- Extended EEG monitoring
- Gastroesophageal reflux
- Continuous blood pressure monitoring
- Snoring
- Body positions, etc.

For a study to be reported as a polysomnogram:

- Studies must be performed for 6 hours
- Sleep must be recorded and staged
- An attendant must be present throughout the course of the study

Diagnostic testing is covered when a patient has the symptoms or complaints of one of the following conditions:

- Narcolepsy
- Sleep Apnea
- Parasomnias

(Refer to LMRP for further definition of conditions.)
Limitations

Diagnostic testing that is duplicative of previous sleep testing done by the attending physician to the extent the results are still pertinent is not covered because it is not medically necessary if there have been no significant clinical changes in medical history since the previous study.

Home sleep testing is not covered.

Polysomonography will not be covered in the following situations:

- For the diagnosis of patients with chronic insomnia
- To preoperatively evaluate a patient undergoing a laser assisted uvulopalatopharyngoplasty without clinical evidence that obstructive sleep apnea is suspected.
- To diagnose chronic lung disease (nocturnal hypoxemia in patients with chronic, obstructive, restrictive, or reactive lung disease is usually adequately evaluated by oximetry.)
- In cases where seizure disorders have not been ruled out
- In cases of typical, uncomplicated, and noninjurious parasomnias when the diagnosis is clearly delineated.
- For patients with epilepsy who have no specific complaints consistent with a sleep disorder.
- For patients with symptoms suggestive of the periodic limb movement disorder or restless leg syndrome unless symptoms are suspected to be

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related to a covered indication for the diagnosis of insomnia related to depression

- For the diagnosis of insomnia related to depression
- For the diagnosis of circadian rhythm sleep disorders (i.e., rapid time-zone change (jet lag), shift-work sleep disorder, delayed sleep phase syndrome, advanced sleep phase syndrome, and non-24-hour sleep wake disorder)

Revenue Codes associated with OP hospital billing:

074X	EEG-general classification
0920	Other diagnostic services-general classification

Refer to the LMRP for ICD-9 or ICD-10 Codes that support medical necessity. These ICD-9 or ICD-10 Codes are updated occasionally by Medicare.

Outpatient Cardiac Rehabilitation

The following conditions must be met in order for an outpatient hospital based cardiac rehabilitation clinic to provide services:

- Recipient must be referred by their attending physician

- Services must be medically necessary and include at least one of the following medical conditions:

  1. Have a documented diagnosis of acute myocardial infarction within the preceding 12 months.
  2. Began the program within 12 months of coronary bypass surgery.
  3. Have stable angina pectoris (evaluation of chest pain must be done to determine suitability to participate in the cardiac rehabilitation program).
  4. Had heart valve repair/replacement.
  5. Had a percutaneous transluminal coronary angioplasty (PTCA) or coronary stenting; or
  6. Had a heart or heart lung transplant.

- The frequency and duration of the program is usually two to three sessions per week for 12 to 18 weeks. Any services provided past 36 in a year will require prior authorization by Medicaid.

- Coverage may be extended with sufficient documentation that the patient has not reached the exit level, but will not exceed a maximum of 72 visits annually.

- Each exercise session must include at least one of the following: Continuous cardiac monitoring during exercise and EKG rhythm strip with interpretation and physician's revision of treatment; or examination by the physician to adjust medications or for other treatment changes.

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- No more than one EKG stress test with physician monitoring at the beginning of the exercise program with a repeat test in three months is reasonable and necessary. The medical necessity for stress tests in excess of the two allowed must be clearly established in the recipient's medical record.

- A physician must be immediately available in the exercise program area in case of emergency.

- Formal patient education services are not reasonable and necessary when provided as part of a cardiac rehabilitation exercise program; therefore, Medicaid will not pay for these services.

Outpatient Newborn Hearing Screenings

Inpatient newborn hearing screenings are considered an integral part of inpatient hospital services. Outpatient facility services for newborn screenings are considered covered only in the following circumstances:

- Comprehensive hearing screen codes 92585, 92588 or 92558 may be billed in an outpatient hospital setting for the following circumstances: 1) infants who fail the newborn hearing screening prior to discharge from the hospital, or 2) infants/children fail a hearing screening at any time following discharge. Comprehensive hearing screenings should be performed on infants by three months of age if they failed the newborn hearing screening prior to discharge.

- Limited hearing screen codes 92586 and 92587 may be billed in an outpatient hospital setting for the following circumstances: 1) an infant was discharged prior to receiving the inpatient hearing screen, or 2) an infant was born outside a hospital or birthing center.

Prior Approval for Outpatient Services

Certain procedures require prior authorization. Please refer to Section 19.5.2, Revenue Codes, Procedure Codes, and Modifiers, and Appendix I, ASC Procedures List. Medicaid will not pay for these procedures unless authorized prior to the service being rendered. All requests for prior approval must document medical necessity and be signed by the physician. It is the responsibility of the physician to obtain prior authorization for any outpatient surgical procedure to be performed in an outpatient hospital.

Providers will be required to request a PA from eviCore for all MRI's, MRA's, CT scans, CTA's, and PET scans performed.

The PA requirements will apply to Medicaid recipients who have **full** Medicaid eligibility as defined in Verifying Recipient Eligibility Chapter 3. Scans performed as an inpatient hospital service, as an emergency room service, or for Plan First, SOBRA Adult, or Medicaid Recipients who are also covered by Medicare are exempt from the PA requirement.

Send PA requests for outpatient diagnostic imaging procedures to eviCore by:

- Phone at (855) 774-1318
- Fax at (888) 693-3210

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- Website at www.evicore.com.

(Normal business hours for phone or fax are 7:00 a.m. to 8:00 p.m. central time). Please refer to Chapter 22, Independent Radiology.

Payment of Outpatient Hospital Services

Refer to the *Alabama Medicaid Administrative Code, Chapter 23, Hospital Reimbursement* for details on current hospital payment methodology.

Extracorporeal Shock Wave Lithotripsy (ESWL)

Extracoporeal Shock Wave Lithotripsy (ESWL) is a covered benefit for treatment of kidney stones in the renal pelvis, uretero-pelvic junction, and the upper one-third of the ureter. ESWL is **not** a covered service for urinary stones of the bladder and the lower two-thirds of the ureter.

For ESWL treatment to both kidneys during the same treatment period, Medicaid will pay the facility one-and-a-half time the regular reimbursement rate for this procedure. Repeat ESWL treatments on the same recipient within a ninety-day period will be reimbursed at half the regular reimbursement rate for this procedure.

The ESWL reimbursement rate is an all-inclusive rate for each encounter and all services rendered in conjunction with the treatment (with the exception of the physician's and the anesthesiologist's) are included in the rate, such as lab, x-ray, and observation.

For repeat ESWL treatments on the same recipient within a ninety-day period, Medicaid will reimburse the surgeon at half the regular reimbursement rate for the surgical procedure.

Physician (surgeon) services for the ESWL procedure are not included in the facility's reimbursement rate and can be billed separately. No assistant surgeon services will be covered.

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

19.2.6 Outpatient and Inpatient Tests

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

Hospital labs may bill 'routine venipuncture' only for collection of laboratory specimens when sending blood specimens to another site for analysis. Hospital labs may bill Medicaid on behalf of the reference lab that a specimen is sent to for analysis. Payment may be made to the referring laboratory but only if one of the following conditions is met:

- The referring laboratory is located in, or is part of, a rural hospital;
- The referring laboratory is wholly owned by the entity performing such test, the referring laboratory wholly owns the entity performing such test, or both the referring laboratory and the entity performing such test are wholly-owned by a third entity; or

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- The referring laboratory does not refer more than 30 percent of the clinical laboratory tests for which it receives requests for testing during the year (not counting referrals made under the wholly-owned condition described above).

Chlamydia and Gonorrhea

Effective for dates of service on or after September 1, 2012, Chlamydia (87491) or gonorrhea (87591), when billed on the same date of service for any one patient will deny. If both procedures are performed on the same date of service, procedure code 87801 (infectious agent antigen detection by nucleic acid (DNA or RNA), multiple organisms; amplified probe(s) technique) should be billed instead.

19.2.7 Crossover Reimbursement

Medicare-related claims for QMB recipients are reimbursed in accordance with the coverage determination made by Medicare. Medicare-related claims for recipients not categorized as QMB recipients are paid only if the services are covered under the Medicaid program.

Hospital outpatient claims are subject to Medicaid reimbursement methodology.

When a Medicaid recipient has third party health insurance of any kind, including Medicare, Medicaid is the payer of last resort. Thus, provider claims for Medicare/ Medicaid-eligible recipients and QMB-eligible recipients must be sent first to the Medicare carrier. An aged, outdated claim which is timely submitted to Medicare must be received by the fiscal agent within 120 days of the disposition date.

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.

Part A

Medicaid covers the Part A deductible, coinsurance, or lifetime reserve days, less any applicable copayment.

Exhausted Benefits

Medicaid will pay Part A claims for Medicare recipients who have exhausted their life-time Medicare benefits. Those claims must be filed directly to

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Medicaid on a UB-04 claim form along with a supporting Medicare EOB that shows the recipient has exhausted Medicare benefits. When filing the UBO4, Medicaid liability begins with charges incurred after Medicare benefits were exhausted. In block 32 of the UBO4 claim form enter occurrence code A3 (benefits exhausted) and the last date of Medicare entitlement. All documents should be mailed to: Alabama Medicaid, P O Box 5624, Montgomery, Alabama 36103-5624 Attn: Institutional Services Unit.

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

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 ACHN Program, refer to Chapter 40, to determine whether your services require a referral from the Primary Care Physician (PCP).

Prior authorization is required for certain outpatient surgical procedures. Refer to Appendix I or the Outpatient Fee Schedule on the website: www.medicaid.alabama.gov. Prior authorization is not required for inpatient admissions.

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

NOTE:

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

19.4 Cost Sharing (Copayment)

The copayment amount for an inpatient admission (including crossovers) is $50.00 per admission. This includes bill types 111, 112, 121, and 122 only (with the exception of admit types 1-emergency and 5-trauma).

The copayment amount for an outpatient visit (99281– 99285) is $3.90 per visit or $3.90 per total bill for crossover outpatient hospital claims. The provider may not deny services to any eligible Medicaid recipient because of the recipient's inability to pay the cost - sharing (copayment) amount imposed.

Copayment does not apply to services provided for pregnant women, nursing facility residents, recipients less than 18 years of age, family planning, renal dialysis, chemotherapy, radiation therapy, physical therapy, and certified emergencies (excluding crossovers). Native American Indians that present an "active user letter" issued by Indian Health Services (IHS) will be exempt from the Medicaid required copayment.

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NOTE:

Medicaid's copayment is not a third party resource. Do not record copayment on the UB-04.

19.5 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

Hospitals that bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

Medicaid's copayment is not a third party resource. Do not record copayment on the UB-04.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

All inpatient and outpatient claims must contain a valid physician's license number in field 76 of the UB-04 claim form.

Certified Emergency Outpatient Visits

Section 19.2.5, Outpatient Hospital Services, states the visit must be certified as such in the medical record and signed by the attending licensed physician, nurse practitioner or provider assistant at the time of the visit. Only one emergency room visit per day per provider will be reimbursed by Medicaid. Refer to Chapter 5 (Filing Claims) for claim filing information.

Nonpatient Visits

Specimen and blood samples sent to the hospital for lab work are classified as "nonpatient" since the patient does not directly receive services. This service does not count against the outpatient visit limitations and should be billed as bill type 14X. Refer to Section 5.3, UB-04 Billing Instructions, for description of Type of Bill values.

Recipients with Medicare Part B (Medical Only)

If a Medicaid recipient is Medicare Part B/Medicaid eligible, lab and x-ray procedures are covered under Medicare Part B for eligible recipients. Charges that are covered by Medicare must be filed with Medicare, and Medicaid will process the claim as a crossover claim. The following revenue codes are normally covered for Part B reimbursement (bill type 121): 274,

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

Claims that span a recipient's eligibility change must be split billed.

19.5.1 Time Limit for Filing Claims

Medicaid requires all claims for inpatient and outpatient services and psychiatric hospitals to be filed within one year of the date of service. Refer to Section 5.1.5, Filing Limits and Approved Exceptions, for more information regarding timely filing limits and exceptions.

19.5.2 Revenue Codes, Procedure Codes, and Modifiers

Revenue codes are used for both inpatient and outpatient services. Procedure codes must be used for outpatient services.

Refer to the Official UB-04 Data Specifications Manual for a complete listing of valid revenue codes.

Medicaid uses the Healthcare Common Procedure Coding System (HCPCS). HCPCS is composed of the following:

- American Medical Association's Current Procedural Terminology (CPT)
- Nationally assigned codes developed for Medicare

The CPT manual lists most procedure codes required by Medicaid. This manual may be obtained by contacting the Order Department, American Medical Association, 515 North State Street, Chicago, IL 60610-9986.

This section covers revenue codes, procedure codes, and modifier information under the following topics:

- Outpatient Revenue Codes
- Emergency Department
- Outpatient Observation
- Pharmacy
- Esophagus
- Laboratory Services
- Radiology
- Radiation Therapy
- Blood Transfusions
- Respiratory Services
- Physical Therapy and Occupational Therapy
- Orthotics
- Speech Therapy
- ESWL

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Outpatient Revenue Codes

Medicaid will accept all valid revenue and procedure codes on outpatient claims for dates of service 10/1/04 and after. Reimbursement methodology has not changed; therefore, detail lines with non-covered revenue and procedure codes will continue to deny.

Emergency Department

Emergency and/or outpatient hospital services performed on the day of admission (at the same hospital) must be included on the inpatient billing.

Hospital providers should use the following procedure codes when billing for emergency department services:

CPT Code	*Rev Code*	*Description*
99281	450	Emergency department visit for the evaluation and management of a patient that requires these three components: • A problem-focused history, • A problem-focused examination, and • Straightforward medical decision making
99282	450	Emergency department visit for the evaluation and management of a patient that requires these three components: • An expanded problem-focused history, • An expanded problem-focused examination, and • Medical decision making of low complexity
99283	450	Emergency department visit for the evaluation and management of a patient that requires these three components: • An expanded problem-focused history, • An expanded problem-focused examination, and • Medical decision making of moderate complexity
99284	450	Emergency department visit for the evaluation and management of a patient that requires these three components: • A detailed history, • A detailed examination, and • Medical decision making of moderate complexity
99285	450	Emergency department visit for the evaluation and management of a patient that requires these three components within the constraints imposed by the urgency of the patient's clinical condition and mental status: • A comprehensive history, • A comprehensive examination, and • Medical decision making of high complexity

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NOTE:

The above procedure codes may be billed only for services rendered in a hospital emergency department and must be listed on the UB-04 claim form with revenue code 450. Revenue code 450 should not be billed for surgical procedures provided in the emergency room. In these instances the appropriate ER facility fee (99281-85) must be used. Surgical procedures may be billed only when an operating room has been opened for the surgery. Surgical codes must be billed with revenue code 360.

Outpatient Observation

Outpatient Observation is medically necessary extended outpatient care provided to a patient whose condition warrants additional observation before a decision is made about admission to the hospital or prolonged patient care. Outpatient Observation can be billed for a recipient who has been seen in the Emergency Room or is a maternity recipient whose provider has ordered Observation services.

Outpatient Observation charges (99218-99220) must be billed in conjunction with the appropriate facility fee (99281-99285), except for those maternity recipients whose provider has ordered Observation services.

For the first three hours of Observation, the provider should bill the facility fee (99281-99285) in units of 1, in conjunction with the Observation charges (99218-99220) in hourly increments. Observation charges are limited to 23 hours.

For the 4th -23rd hours of Observation, the provider bills procedure code G0378 with the appropriate facility fee (99281-99285) in units of 1.

For Observation Services that spans midnight (recipient is discharged from Observation and admitted to the hospital **after** midnight) the provider bills all Observation charges, using the admission date to Observation Services, rendering the Per Diem method of payment in effect on the date of admission to Observation Services.

For Observation Services that does NOT span midnight (recipient is discharged from Observation and admitted to the hospital on the same day **before** midnight) the provider bills all Observation charges with the inpatient charges. In other words, bill for the first 3 hours as noted above, then bill the Per Diem for each day with inpatient status.

Ancillary charges (lab work, x-ray, etc.) may be billed with the Observation charge.

Outpatient Observation charges cannot be billed in conjunction with outpatient surgery or critical care.

Revenue code 76X is used in conjunction with procedure code G0378 and the appropriate facility fee (99281-99285)

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Pharmacy

Revenue code 250 applies to Pharmacy - Injectable Drugs (includes immunization).

See Appendix H of this manual for more information.

Esophagus

Use revenue code 309 with a valid procedure code for Esophagus - Acid reflux test.

Laboratory Services

Use revenue codes 300-310 with valid CPT codes for Laboratory services.

NOTE:

Services may be span billed if claim contains lab procedure codes. Refer to Section 5.3, UB-04 Billing Instructions, for information on span billing.

Radiology

Use revenue codes 320-331 with valid CPT codes for radiology. Refer to Chapter 22, Independent Radiology, for procedure codes that require prior authorization.

Radiation Therapy

Use revenue code 333 with procedure codes 77261-77790 for radiation therapy.

Blood Transfusions

Procedure code 36430 should be billed only once a day regardless of how many units were administered during that episode.

Revenue Code	*Procedure Code*	*Description*
39X	36430	Transfusion, blood or blood components

Respiratory Services

Revenue Code	*Procedure Code*	*Description*
412	94010	Spirometry, including graphic record, vital capacity, expiatory flow rate
412	94060	Bronchospasm evaluation
412	94150	Vital capacity total
412	94200	Maximum breathing capacity
412	94240	Functional residual capacity
412	94350	Pulmonary function test, lung volume
412	94360	Determination of resistance to airflow
412	94370	Determination of airway closing volume, (PFT S/B oxygen)
412	94375	Respiratory flow volume loop
412	94620	Pulmonary stress testing
412	94664	Aerosol or vapor inhalations for diagnosis

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Revenue Code	*Procedure Code*	*Description*
412	94665	Aerosol or vapor inhalations for sputums
412	94720	PFT - diffusion
412	94642	Aerosol inhalation of pentamidine for pneumocystis carinii (pneumonia treatment for Prophylaxis)
412	94650	Inhalation Services - Intermittent pressure breathing-treatment, air or oxygen, with or without medication
412	94680	Oxygen uptake
412	94770	Carbon Dioxide, expired gas determination
412	94772	Pediatric Pneumogram

Physical Therapy and Occupational Therapy

Procedure codes listed below may be billed by a PT or OT. Procedure codes marked with * must be billed in conjunction with therapeutic codes (97110-97542). Use revenue code 42X for PT claims and revenue code 43X for OT claims.

Procedure Code	*Physical Therapy*	*See Note*	*Max Units*	*Annual Limit*
97010	Application of a modality to one or more areas; hot or cold pack	1, 3	1	12
95831	Muscle testing, manual (separate procedure) extremity (excluding hand) or trunk, with report	1	1	12
95832	Muscle, testing, manual, hand		1	12
95833	Total evaluation of body, excluding hands		1	12
95834	Total evaluation of body, including hands		1	12
95851	ROM measurements and report (separate procedure); each extremity (excluding hand) or each trunk section (spine)		10	10
97161	Evaluation of physical therapy, low complexity, typically 20 minutes		1	1
97162	Evaluation of physical therapy, moderate complexity, typically 30 minutes		1	1
97163	Evaluation of physical therapy, high complexity, typically 45 minutes		1	1
97164	Re-evaluation of physical therapy, typically 20 minutes		1	
97165	Evaluation of occupational therapy, low complexity, typically 30 minutes		1	1
97166	Evaluation of occupational therapy, moderate complexity, typically 45 minutes		1	1

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Procedure Code	*Physical Therapy*	*See Note*	*Max Units*	*Annual Limit*
97167	Evaluation of occupational therapy, high complexity, typically 60 minutes		1	1
97168	Re-evaluation of occupational therapy established plan of care, typically 30 minutes		1	1
97012*	Traction, mechanical*	1	1	12
97014*	Electrical stimulation, unattended*	1, 2	4	12
97016	Vasopnueumatic device*		1	12
97018*	Paraffin bath*	1, 3	1	24
97020*	Microwave*	3	1	24
97022	Whirlpool	3	1	24
97024*	Diathermy*	1	1	24
97026*	Infrared*	1	1	24
97028	Ultraviolet		1	24
97032	Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes	3	4	96
97033	Lontophoresis, each 15 minutes	3	4	96
97034	Contrast baths, each 15 minutes	3	4	96
97035	Ultrasound, each 15 minutes	3	4	96
97036	Hubbard tank, each 15 minutes	3	4	96
97110	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, ROM and flexibility	3	4	96
97112	Neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and proprioception	3	1	24
97113	Aquatic therapy with therapeutic exercises*		1	24
97116	Gait training (includes stair climbing)	4	1	18
97124	Massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)	3	1	8
97140	Manual therapy techniques (eg, mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes		1	
97150	Therapeutic procedure(s), group (2 or more individuals)		1	12
97530	Therapeutic activities, direct pt contact by the provider, each 15 minutes	3 and 5	4	96

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Procedure Code	*Physical Therapy*	*See Note*	*Max Units*	*Annual Limit*
97532	Development of cognitive skills to improve attention, memory, problem solving, (included compensatory training), direct (one on one) patient contact by the provider, each 15 minutes	3-4	4	36
97533	Sensory integrative techniques to enhance sensory processing and promote adaptive responses to adaptive responses to environmental demands, direct (one on one) patient contact by the provider, each 15 minutes	3-4	4	36
97542	Wheelchair management/propulsion training, each 15 minutes	3	4	24
97597	Removal of devitalized tissue from wounds	3	1	104
97598	Removal of devitalized tissue from wounds	3	8	104
97750	Physical performance test or measurement, (for example, muscoloskeletal, functional capacity) with written report, each 15 minutes	3	12	12
97760	Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(s), lower extremity(s) and/or trunk, each 15 minutes	3-4	4	16
97761	Prosthetic training, upper and/or lower extremity(s), each 15 minutes	3	4	16
97762	Checkout for orthotic/prosthetic use, established patient, each 15 minutes	3	4	12

NOTE:

1. Restricted to one procedure per date of service (cannot bill two together for the same date of service).
2. 97014 cannot be billed on same date of service as procedure code 20974 or 20975.
3. When a physical therapist and an occupational therapist perform the same procedure for the same recipient on the same day of service, the maximum units reimbursed by Medicaid will be the daily limit allowed for the procedure, not the maximum units allowed for both providers.
4. 97760 should not be reported with 97116 for the same extremity.
5. 97530 requires an EPSDT referral

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Orthotics

NOTE:

Prosthetic/Orthotic devices are covered only when services are rendered to a recipient as a result of an EPSDT screening or to a QMB recipient. Use revenue code 274 when billing L codes.

Orthotics provided by hospitals is limited to the L codes listed below:
L1940
L1970
L3730
L3906
L3923
L4205

Speech Therapy

NOTE:

Speech Therapy is covered only when service is rendered to a recipient as a result of an EPSDT screening or to a QMB recipient. Use revenue code 44X when billing speech therapy codes.

Hospitals may bill the following CPT codes for EPSDT referred speech therapy services.

92506-92508	92597

ESWL

Revenue Code	*Procedure Code*	*Description*
790	50590	Lithotripsy, Extracorporeal shock wave

19.5.3 Diagnosis Codes

The *International Classification of Diseases - 10th Revision - Clinical Modification* (ICD-10-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the
American Medical Association, AMA Plaza 330 North Wabash Ave, Suite 39300 Chicago, IL 60611-5885, or 1-800-621-8335.

NOTE:

ICD-9 codes should be used for claims submitted with dates of service prior to or equal to 09/30/2015.

ICD-10 codes should be used for claims submitted with dates of service on/after 10/01/2015.

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NOTE:

ICD-9 or ICD-10 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

19.5.4 Place of Service Codes

Place of service codes do not apply when filing the UB-04 claim form.

19.5.5 Required Attachments

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

- Claims With Third Party Denials

NOTE:

When an attachment is required, a hard copy UB-04 claim form must be submitted.

Refer to Section 5.8, Required Attachments, for more information on attachments.

19.6 For More Information

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

Resource	Where to Find It
UB-04 Claim Filing Instructions	Chapter 5
Institutional Medicaid/Medicare-related Claim Filing Instructions	Chapter 5
Medical Necessity/Medically Necessary Care	Chapter 7
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N
Outpatient Fee Schedule	www.medicaid.alabama.gov
Lab & X-ray Fee Schedule	www.medicaid.alabama.gov

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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

Medicaid' fiscal agent enrolls Independent Laboratory providers and issues provider contracts to applicants who meet the licensure and certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code*, and the *Alabama Medicaid Provider Manual*.

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

Federal requirements mandate providers re-validate periodically with the Alabama Medicaid program. Providers will receive notification when it is time to re-validate. When the provider fails to re-validate with the appropriate documentation, the provider file will be end-dated. If the providers file is end dated, the provider will be required to submit a new enrollment application.

National Provider Identifier, Type, and Specialty

A provider who contracts with Alabama Medicaid as an independent laboratory provider is added to the Medicaid system with the National Provider Identifier provided at the time the application is made. An appropriately assigned specialty code enables the provider to submit requests and receive reimbursements for laboratory-related claims.

NOTE:
The 10-digit NPI is required when filing a claim.

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Alabama Medicaid uses provider type 28 to identify Independent Laboratory. The valid specialties for Independent Lab providers include the following:

- Independent Lab (280)
- Department of Public Health Lab (550)

Enrollment Policy for Independent Laboratories

To participate in the Alabama Medicaid Program, Independent Laboratories must meet the following requirements:

- Possess certification as a Medicare provider
- Possess certification as a valid CLIA provider if a clinical lab
- Exist independently of any hospital, clinic, or physician's office
- Possess licensure in the state where located, when it is required by that state

Change of Ownership (CHOW) and Closures

Medicaid will mirror Medicare's Change of Ownership (CHOW) policy.

Refer to Chapter 19, Hospital for additional information on Change of Ownership.

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. Refer to Chapter 7, Understanding Your Rights and Responsibilities as a Provider, for general criteria on Medical Necessity/ Medically Necessary Care.

20.2.1 Covered Services

Medicaid reimburses Independent Labs for services described by procedures that may fall within the "8000" ranges in the CPT manual. In some cases, procedures within this range may only be payable to Department of Public Health Lab (550).

Medicaid also pays for procedures defined in the locally assigned Healthcare Common Procedural Coding System (HCPCS) to supplement the listing in the CPT manual.

Medicaid Independent Lab providers receive reimbursement for covered services within their CLIA certification.

Independent Lab providers may only bill for routine venipuncture for collection of laboratory specimens when sending blood specimens to another site for analysis. Labs may not bill the collection fee if the lab work and specimen collection is performed at the same site. Labs may not bill the collection fee if they perform analysis in a lab owned, operated, or financially associated with the site in which the specimen was drawn.

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New Presumptive Drug Class Screening and Definitive Drug Testing

Effective for dates of service on and after **October 1, 2017**, Alabama Medicaid will place limitations on Laboratory Assay Drug Testing, Definitive Drug Testing Presumptive Drug Testing. Medicaid will no longer cover Procedure codes within the range 80320 – 80377 for dates of service on or after October 1, 2017.

The following limitations listed below:

1. Laboratory Assay Drug testing will have a benefit limit of 24 per calendar year.
- Presumptive Testing 12 per calendar year
- Definitive Testing 12 per calendar year

2. The procedure codes must be billed with a quantity of one per date of service regardless of the number of collective/testing items used, the number of procedures, and/or the drug testing screened.

3. Specimen validity testing is not eligible to be separately billed under any procedure code.

Below are some examples of when a Medicaid claim will be denied:

1. If Dr. A bills G0480 on 10/01/2017, and Dr. B bills G0483 on 10/01/2017, only one claim will be paid. If Dr. A bills G0482 or G0481 six (6) times and Dr. B bills G0483 seven (7) times by 12/31/2017, then one claim will be denied because the limit for these four codes is 12 per year.) One (1) presumptive drug test per day, per recipient not to exceed 12 per year will be allowed.

2. If Dr. A bills PC 80305 on 10 /01/2017, and Dr. B bills PC 80307 on 10/01/2017, only one claim will be paid. If Dr. A bills PC 80305 or 80307 six (6) times and Dr. B bills PC 80306 seven (7) times by 12/31/2017, then one claim will be denied because the limit for these three codes is 12 per year.

Medicaid will review and verify that requirements for the Laboratory Drug Assay are being met. Paid claims to providers that do not meet these requirements may be subject to recoupment.

Presumptive Drug testing reported value may be qualitative, semi-quantitative or quantitative depending on the purpose of the testing. A qualitative drug screen detects the presence of a drug in the body. A quantitative test tells you the amount (the quantity) that is present. Methods that cannot distinguish between structural isomers (such as morphine and hydromorphone) are considered presumptive. ALL drug class immunoassays are considered presumptive, whether qualitative, semi-quantitative, or quantitative values are provided.

Definitive drug class procedure are qualitative or quantitative test to identify specific/ individual drugs. These screening code are limited to one 24 per calendar year (12 Presumptive and 12 Definitive) per recipient, regardless of the provider. The following codes are covered by Medicaid for presumptive and definitive screening/ testing:

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Presumptive Drug Class Screening CPT Code	Definitive Drug Testing
80305 - Drug screen, presumptive, any number of drug classes any number of devices or procedures, (e.g. immunoassay) capable of being read by direct optical observation only (e.g., dipstick, cups, cards, cartridge), includes sample validation when performed, per date of service.	**G0480** - Drug test(s), definitive, utilizing (1) drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase)), (2) stable isotope or other universally recognized internal standards in all samples (e.g., to control for matrix effects, interferences and variations in signal strength), and (3) method or drug-specific calibration and matrix-matched quality control material (e.g., to control for instrument variations and mass spectral drift); qualitative or quantitative, all sources, includes specimen validity testing, per day; 1-7 drug class(es), including metabolite(s) if performed
80306 - Drug screen, presumptive, any number of drug classes, qualitative, any number of devices or procedures (e.g., immunoassay) read by instrument assisted direct optical observation (e.g., dipstick, cups, cards, cartridge),, includes sample validation when performed, per date of service	**G0481** - Drug test(s), definitive, utilizing (1) drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase)), (2) stable isotope or other universally recognized internal standards in all samples (e.g., to control for matrix effects, interferences and variations in signal strength), and (3) method or drug-specific calibration and matrix-matched quality control material (e.g., to control for instrument variations and mass spectral drift); qualitative or quantitative, all sources, includes specimen validity testing, per day; 8-14 drug class(es), including metabolite(s) if performed
80307 - (Drug test(s), presumptive, any number of drug classes, qualitative, any number of devices or procedures by instrument chemistry analyzers (e.g., utilizing immunoassay [e.g., EIA, ELISA, EMIT, FPIA, IA, KIMS, RIA]), chromatography (e.g., GC, HPLC), and mass spectrometry either with or without chromatography, (e.g., DART,	**G0482** - Drug test(s), definitive, utilizing (1) drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic

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Presumptive Drug Class Screening CPT Code	Definitive Drug Testing
DESI, GC-MS, GC-MS/MS, LC-MS, LC-MS/MS, LDTD, MALDI, TOF) includes sample validation when performed, per date of service.)	methods (e.g., alcohol dehydrogenase)), (2) stable isotope or other universally recognized internal standards in all samples (e.g., to control for matrix effects, interferences and variations in signal strength), and (3) method or drug-specific calibration and matrix-matched quality control material (e.g., to control for instrument variations and mass spectral drift); qualitative or quantitative, all sources, includes specimen validity testing, per day; 15-21 drug class(es), including metabolite(s) if performed
	G0483 - Drug test(s), definitive, utilizing (1) drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase)), (2) stable isotope or other universally recognized internal standards in all samples (e.g., to control for matrix effects, interferences and variations in signal strength), and (3) method or drug-specific calibration and matrix-matched quality control material (e.g., to control for instrument variations and mass spectral drift); qualitative or quantitative, all sources, includes specimen validity testing, per day; 22 or more drug class(es), including metabolite(s) if performed

NOTE:

Use the appropriate chemistry code (82009-84999) for quantitation of drugs screened, and the appropriate therapeutic drug assay code (80150-80299) for therapeutic drug levels.

Coverage Criteria

Medicaid will cover medically necessary qualitative drug screens as follows:

1. Suspected drug overdose, indicated by one or more of the following conditions:
   - Unexplained delirium or coma;
   - Unexplained altered mental status;
   - Severe or unexplained cardiovascular instability (cardiotoxicity);
   - Unexplained metabolic or respiratory acidosis;

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- Unexplained head trauma with neurological signs and symptoms; and/or,
- Seizures with an undetermined history.

2. Beneficiary presents with clinical signs/symptoms of substance abuse.
3. High risk pregnancy only when the documented patient history demonstrates that the procedure is medically necessary. Medicaid does **not** consider a qualitative drug screen as a routine component of assessment.
4. EPSDT services only when the documented patient history demonstrates that the procedure is medically necessary. Medicaid does **not** consider a qualitative drug screen as a routine component of assessment.

Exclusions

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

- To screen for the same drug with both a blood and a urine specimen simultaneously.
- For medicolegal purposes, including those listed under ICD-10 codes Z02.81 and Z02.83 (Blood-alcohol tests, paternity testing and blood-drug tests).
- For employment purposes (i.e., as a pre-requisite for employment or as a means for continuation of employment).
- For active treatment of substance abuse, including monitoring for compliance.
- As a component of routine physical/medical examination ICD-10 codes Z00.12, Z02.0, Z02.1, Z02.2, Z02.3, Z02.89 and Z11.3- health exam of defined subpopulations, (Armed forces personnel, Inhabitants of institutions, Occupational health examinations, Pre-employment screening, preschool children, Prisoners, Prostitutes, Refugees, School children and Students).
- As a component of medical examination for administrative purposes, including those listed under ICD-10 code Z02.0, Z02.2, Z02.4, Z02.82 and Z02.89. (General medical examination for: admission to old age home, adoption, camp, driving license, immigration and naturalization, insurance certification, marriage, prison, school admission and sports competition).

Prior Approval

Prior approval will not be required for qualitative or quantitative drug screens.

Documentation Requirements

For all tests, a written order is required indicating the drug/drug class to be screened. Blanket orders are not acceptable.

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If the provider performing the service is other than the ordering/referring provider, the provider must maintain (hardcopy) documentation detailing the drugs/drug classes ordered by the provider.

The ordering/referring and/or performing provider must retain the following in the medical record:

- A copy of the test requisition (actual paperwork that identifies the test or tests to be performed)
- All medical documentation validating Medical Necessity of ordered services
- A copy of the lab results

Documentation must be legible and available for review upon request.

Chlamydia and Gonorrhea

Effective on or after September 1, 2012, Chlamydia (87491) or Gonorrhea (87591), when billed on the same date of service will deny. Use 87800 or 87801 when performing combined chlamydia and gonorrhea testing if both procedures are performed on the same date of service.

- **87800** Infectious agent detection by nucleic acid (DNA and RNA), multiple organisms; direct probes technique
- **87801** Infectious agent detection by nucleic acid (DNA and RNA), multiple organisms; AMPLIFIED probes technique

When using nucleic acid amplification techniques to test for a single infectious organism that lacks a specific CPT code, a single unit of CPT 87798 should be billed instead.

End Stage Renal Disease (ESRD) Laboratory Services

Laboratory tests listed in Chapter 35 (Renal Dialysis Facility) are considered routine and are included in the composite rate of reimbursement. When any of these tests are performed at a frequency greater than specified, the additional tests are separately billed and are covered only if they are medically necessary and billed directly by performing provider. A diagnosis of ESRD alone is not sufficient medical evidence to warrant coverage of additional tests. The nature of the illness or injury (diagnosis, complaint, or symptom) requiring the performance of the test(s) must be present on the claim.

20.2.2 Non-Covered Services

Medicaid does not pay packing and handling charges for referred laboratory services. The referred laboratory receives payment for referred tests only at the normal rate. Medicaid shall monitor this policy through post-payment review.

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20.2.3 Clinical Laboratory Improvement Amendments (CLIA)

All laboratory testing sites providing services to Medicaid recipients, either directly by provider, or through contract, must be CLIA certified to provide the level of complexity testing required. The Independent Lab must adhere to all CLIA regulations. As regulations change, Independent Labs must modify practices to comply with the changes. Providers are responsible for providing Medicaid waiver or certification numbers as applicable.

Laboratories which do not meet CLIA certification standards are not eligible to provide services to Medicaid recipients or to participate in Medicaid.

NOTE:

The Health Care Financing Administration (HCFA), now known as CMS, implemented the Clinical Laboratory Improvement Amendments of 1988 (CLIA 88), effective for dates of service on or after September 1, 1992. The CLIA regulations were published in the February 28, 1992 Federal Register. More detailed information regarding CLIA can be found at http://www.cms.hhs.gov/clia/

CLIA certificates are based on the complexity of the test and 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

Access a complete listing of laboratory procedures limited to waived certificates (level 2 certification) and PPMP certificates (level 4 certification) via the CMS website.

The Trofile Assay will be a covered service by Medicaid with prior authorization (PA) effective December 1, 2008, using CPT 87999 (unlisted microbiology procedure). Medicaid reimburses the Trofile Assay when the ordering provider submits a Prior Authorization electronically or by paper on form 342. The fiscal agency must receive the PA request within 30 days of the date of service.

Providers requesting a PA should include:

- Any past history of antiretroviral medications prescribed to include date prescribed and the date the drug was discontinued;
- The name and contact information of the HIV clinic that the provider is affiliated with if the requesting provider is not enrolled in Medicaid with specialty of infectious disease, and;
- The result of the most current HIV-1 RNA.

If you need further information, refer to chapter 4, Obtaining Prior Authorization, for general guidelines.

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20.3 Cost Sharing (Copayment)

Copayment amount does not apply to services provided for laboratory services.

20.4 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

Independent Laboratory providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When filing a paper claim, a CMS-1500 claim form is required. Medicare-related claims must be filed using the Medical Medicaid/Medicare-related Claim Form 340. All paper claims must be a one page red drop ink form.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

20.4.1 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 Chapter 5, Filing Limits, for more information regarding timely filing limits and exceptions.

20.4.2 Diagnosis Codes

Claims for lab services must contain a valid diagnosis code. The *International Classification of Diseases - 10th Revision - Clinical Modification* (ICD-10-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, AMA Plaza 330 North Wabash Ave, Suite 39300 Chicago, IL 60611-5885, or 1-800-621-8335.

NOTE:

ICD-10 codes should be used for claims submitted with dates of service on/after 10/01/2015. ICD-10 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.

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20.4.3 Procedure Codes and Modifiers

Medicaid uses the Healthcare Common Procedure Coding System (HCPCS). HCPCS is composed of the following:

- American Medical Association's Current Procedural Terminology (CPT)
- Nationally assigned codes developed for Medicare
- Locally assigned codes issued by Medicaid. Effective for dates of service on or after 01/01/2004, use national codes.

The CPT manual lists most procedure codes required by Medicaid. To obtain this manual contact the following.

American Medical Association

Attn.: Order Department

515 North State Street

Chicago, IL 60610-9986

Medicaid denies claims without procedure codes or with codes that are invalid. Medicaid also recognizes modifiers when applicable. The (837) Institutional electronic claim and the paper claim can be modified to accept up to four Procedure Code Modifiers. The following sections describe modifiers that may apply to a procedure code when filing claims for independent lab services.

The following sections describe modifiers that may apply to a procedure code when filing claims for independent lab services.

Modifier 91 - Repeat Laboratory Procedures

Modifier 91 should be appended to laboratory procedure(s) or service(s) to indicate a repeat of clinical diagnostic laboratory test or procedure on the same day. This modifier indicates to the carriers or fiscal intermediaries that the physician had to perform a repeat clinical diagnostic laboratory test that was distinct or separate from a lab panel or other lab services. This should not be appended to the initial lab procedure code. Modifier '91' may not be used when laboratory tests are rerun:

- To confirm initial results
- Due to testing problems encountered with specimens or equipment
- For any other reason when a normal, one-time, reportable result is all that is required.
- When the code being used or other codes describe a series of test results (e.g., glucose tolerance tests, evocative/suppression testing).

Modifier 76 – Repeat Laboratory Modifier

Modifier 76 is reported to communicate that a service or procedure was repeated by the same practitioner subsequent to the original procedure or service. This modifier may be used whenever the circumstances warrant the repeat procedure. Based on the definition of modifier 76, it would be inappropriate to append modifier 76 to clinical laboratory tests on the same day.

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Modifier 77 – Repeat Laboratory Procedure

Repeat procedure/ service performed by another physician or other qualified health care professional. This modifier may be used for billing multiple services on the same day and the service cannot be quantity billed. It is inappropriate to use with services considered bundled.

Modifier 59 - Distinct Procedural Service

This modifier indicates that one procedure/ service is distinct and independent of another procedure/ service performed on the same day. These services are not normally reported together, but are appropriate under the circumstances.

Modifier 59 is an important NCCI- associated modifier. Its primary purpose is to indicate that two or more procedures are performed at different anatomic sites or different patient encounters. Claims billed with the same procedure two or more times for the same date of service, should be submitted with the appropriate repeat procedure modifier rather than using Modifier 59.

Modifier 26 – Professional Component

Modifier 26 is used to indicate that the physician component for the diagnostic (interpretation of a test) is reported separately from the technical component.

Modifier TC (Technical Component)

Modifier TC is used to indicate the technical component of the diagnostic procedure is reported separately from the professional component. Do not submit the technical component separately when one physician performs both the professional and technical component on the same day.

NOTE:
Claims submitted for a repeat of the same procedure on the same date of service without modifiers will be denied as duplicate services.

Blood Specimens

Collection of laboratory specimens may be billed only when sending specimens to another site for analysis if the other site is not owned, operated, or financially associated with the site in which the specimen was collected.

The collection fee may not be billed if the lab work is done at the same site where the specimen was collected or in a lab owned, operated, or financially associated with the site in which the specimen was collected.

Independent laboratory providers will not be paid for and should not submit claims for laboratory work done for them by other independent laboratories or by hospital laboratories.

Providers may submit claims for laboratory work done by them in their own laboratory facilities.

A hospital lab may bill Medicaid on behalf of the reference lab that a specimen is sent to for analysis. It is the responsibility of the referring lab (hospital) to make sure that the reference lab does not bill these services to Medicaid.

Providers who send specimens to another independent laboratory for analysis may bill a collection fee. This fee shall not be paid to any provider who has not actually extracted the specimen from the patient.

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NOTE:

Providers should use procedure code 36415-90 for routine venipuncture collection, 36416-90 for collection of capillary blood specimen (eg, finger, heel, ear stick) and Q0091-90 for collection of Pap smear specimen.

Laboratory Paneling and Unbundling

A *panel* is a group of tests performed together or in combination. Medicaid follows the CPT guidelines for panel tests.

Unbundling occurs when the procedures, services and supplies are listed with their own separate, distinct codes. This refers to the practice of using more than one procedure code to bill for a procedure that can more appropriately be described using fewer codes. The use of unbundled codes results in denial of payment, with the exception of organ and disease panels.

All organ and disease oriented panels must include the tests listed with no substitutions. If only part of the tests included in a defined panel is performed, the panel code should not be reported. If additional tests to those indicated in a panel are performed, those tests should be reported separately in addition to the panel code. If two panels overlap, the physician or laboratory will be required to unbundle one of the panels and bill only for the tests that are not duplicative.

Urinalysis – Claims for the same recipient billed by the same provider that contain two or more of the following services (81000, 81001, 81002, 81003, 81005, 81007, 81015, and 81020) for the same date of service will be considered an unbundled service and will be denied.

During post-payment review, Medicaid may recoup payment from providers for claims submitted containing unbundling of laboratory services.

Oncotype DX™

Effective for dates of service, July 1, 2013 and thereafter, Medicaid will cover the Oncotype DX™ genetic profiling lab test if the patient meets Medicaid's prior authorization criteria. (PA). The PA must be received by the fiscal agent within 30 days of the date of service.

Oncotype DX™ is a genetic profiling test developed to classify the risk of recurrence among women treated for early stage breast cancer.

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

- Newly diagnosed, primary, early stage breast cancer (stage I or stage II) in a female without significant co-morbidities;
- Unilateral, non-fixed tumor;
- Hormone receptor positive (ER-positive or PR-positive);
- HER2-negative;

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- Tumor size 0.6-1cm with moderate/poor differentiation or unfavorable features OR tumor size > 1cm;
- Node negative; (lymph nodes with micrometastases [<2 mm in size] are considered node negative for this policy statement)
- Will be treated with adjuvant endocrine therapy, e.g., tamoxifen or aromatase inhibitors; AND
- When the test result will aid the patient in making the decision regarding chemotherapy (i.e., when chemotherapy is considered a therapeutic option); AND
- When ordered within 6 months following breast cancer diagnosis.

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

Billing providers must bill procedure code 81519 (Test for detecting genes associated with breast cancer).

The Oncotype DX™ will be exempt from Alabama Coordinated Health Network (ACHN) and EPSDT requirements. Enrolled Physicians order the test and an enrolled independent lab performs the test.

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

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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.

20.4.4 Place of Service Codes

The only valid Place of Service Codes for Independent Laboratory providers is 81.

POS Code	*Description*
81	Independent Laboratory

20.4.5 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 on page paper copy CMS-1500 red drop ink claim form must be submitted.

Refer to Chapter 5, for more information on attachments.

20.5 For More Information

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

Resource	Where to Find It
CMS-1500 Claim Filing Instructions	Chapter 5
Medical Medicaid/Medicare-related Claim Filing Instructions	Chapter 5
Medical Necessity/Medically Necessary Care	Chapter 7
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N

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21 Certified Registered Nurse Practitioner (CRNP) and Physician Assistant (PA)

This chapter describes services for which Medicaid payment be made to a certified registered nurse practitioner (CRNP) or physician assistant (PA). The CRNP/PA who is licensed by the state and certified by the appropriate national organization may participate in the Alabama Medicaid Program.

For additional information regarding services performed by a physician-employed CRNP or PA, refer to section 28.2.1 in Chapter 28 of the Provider Billing Manual.

A nurse practitioner or physician assistant who is employed by and reimbursed by a facility that receives reimbursement from the Alabama Medicaid Program for services provided by the nurse practitioner (i.e. hospital, rural health clinic, etc.) may not enroll, if their services are already being paid through that facility's cost report.

The policy provisions for nurse practitioners can be found in the *Alabama Medicaid Agency Administrative Code,* Chapter 49 and for physician assistant, Chapter 6.

21.1 Enrollment

Gainwell enrolls nurse practitioners and physician assistants and issues provider contracts to applicants who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code*, and the *Alabama Medicaid Provider Manual*.

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

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

National Provider Identifier, Type, and Specialty

A provider who contracts with Alabama Medicaid as an CRNP or PA is added to the Medicaid system with the NPI provided at the time application is made. Appropriate provider specialty codes are assigned to enable the provider to submit requests and receive reimbursements for CNRP or PA-related claims.

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NOTE:

The 10-digit NPI is required when filing a claim.

CRNPs are assigned a provider type of 09 (Nurse Practitioner). Valid specialties for CRNPs include the following:

- EPSDT Screening (560)
- Family Practice (092)
- Geriatrics (320)
- Neonatology (730)
- Nurse Practitioner (093)
- QMB/EPSDT (600)
- Plan First (700)
- Pediatrics (090)
- SBIRT (911)
- Women's Health Care (091)
- Vaccines for Children (900)
- Telemedicine Service (931)
- CRNA (094)
- Midwife (095)
- Other (093)

For information on services performed by Certified Registered Nurse Anesthetists refer to Chapter 38 – Anesthesiology. For information on services performed by Certified Nurse Midwives, refer to Chapter 25 – Nurse Midwife.

PAs are assigned a provider type of 10 (Physician Assistant). Valid specialties for PA:

- Anesthesiology Assistant (101)
- Dental Prevention (274)
- EPSDT Screening (560)
- Plan First (700)
- Physician Assistant (100)
- SBIRT (911)
- Vaccines for Children (900)
- Telemedicine Service (931)

Enrollment Policy for CRNP Providers

To participate in the Alabama Medicaid Program, nurse practitioners must meet the following requirements:

- Proof of current Alabama registered nurse licensure
- Copy of current certification as a certified registered nurse practitioner in the appropriate area of practice from a national certifying agency recognized by Medicaid

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- Copy of the certified registered nurse practitioner protocol signed by a collaborating physician

Please see Chapter 28 section titled Physician-Employed Practitioner Services for information related to **physician-employed nurse practitioners**.

- The **independent nurse practitioner's** collaborating physician is not required to be an actively enrolled Medicaid provider to participate in the Medicaid program, but the CRNP must be linked under an active billing group. The CRNP's collaborating physician must align with records from the Alabama Board of Medical Examiners (ALBME).

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.
- Refer to Chapter 7, Understanding Your Rights and Responsibilities as a Provider, for general criteria on Medical Necessity/ Medically Necessary Care
- Refer to Chapter 13, section 13.2 for instructions on administering and billing dental varnishing procedures.
- Refer to Chapter 14 – Durable Medical Equipment (DME), supplies, Appliances, Prosthetics, Orthotics and Pedorthics (POP) for more information on the requirements for the initial written prescription/order for certain medical supplies, equipment, and appliances.
- Refer to Chapter 17 – Home Health for more information on the requirements for placing the initial written prescription/order for home health services.
- Refer to Chapter 40, Alabama Coordinated Health Network (ACHN), for general benefit information and limitations.
- Refer to Chapter 112, Telemedicine Service, for general benefit information and limitations.

CRNP and PA services are **limited** to the injectable drug codes referenced in Appendix H - Alabama Medicaid Physician Administered Drugs, all laboratory services, which are CLIA certified, and certain CPT codes or HCPCS codes.

Effective July 1, 2019, procedure codes that a CRNP/PA may bill have been updated. Please refer to the **Nurse Practitioner/Physician Assistant Fee Schedule** on the Alabama Medicaid website, www.medicaid.alabama.gov. Click on Providers, Fee Schedules, "I Accept" on the user agreement, Nurse Practitioner/Physician Assistant Fee Schedule. The fee schedule may not include all procedure codes covered for a CRNP/PA. For more specific information on coverage, you may call the Provider Assistance Center at 1 (800) 688-7989. The CRNP or PA is responsible for making sure the procedure code service being performed is within their scope of practice. For a CRNP or PA that has a signed EPSDT Provider Agreement on file with the fiscal agent, CPT codes 99381-99385 EP and 99391-99395 EP may also be billable.

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A CRNP/PA may be reimbursed at 100% for lab and injectable drugs. Lab codes allowed are based on CLIA certification.

In order to bill for the administration fee for Vaccines for Children, providers must be enrolled as a VFC provider.

Effective August 01, 2018, an initial prescription or order for home health services and certain medical supplies, equipment and appliances must be signed by a physician.

NOTE:

A CRNP/PA can make physician-required visits to nursing facilities. If a physician makes required inpatient visits to hospitals or other institutional settings, the service should be billed under the physician's NPI. If a CRNP/PA makes inpatient visits to hospitals or other institutional settings, the service should be billed under the CRNP/PAs NPI. A physician and a CRNP/PA may not bill for same services performed on the same day for the same recipient.

21.2.1 Assistant at Surgery Codes

Medicaid requires the use of modifier AS to report non-physician assistant-at-surgery services. When a CRNP/PA assists a surgeon, Medicaid requires that the claim be submitted under the CRNP/PA's name with his or her provider number and with modifier AS appended to the reported surgical code(s). In general, Medicaid recognizes modifier AS according to Medicare standards.

For more specific information on coverage, please review the Practitioner Fee Schedule at www.medicaid.alabama.gov or call the Provider Assistance Center at 1-800-688-7989.

The following list of procedure codes require the AS modifier to report non-physician assistant-at-surgery services:

Added: The following list…29914 32035 49553

Procedure Codes that Require the AS Modifier									
12018	23462	24635	27052	27332	27487	27828	29888	31611	49492
20937	23465	24665	27054	27333	27488	27829	29889	31634	49495
22325	23470	24666	27059	27334	27495	27832	29891	31750	49496
22326	23473	24685	27067	27335	27506	27846	29892	31755	49500
22327	23474	24802	27070	27337	27507	27848	29894	31760	49501
22328	23485	25135	27071	27339	27511	27870	29895	31766	49505
22595	23490	25136	27075	27345	27513	27871	29897	31770	49505
22600	23515	25170	27076	27347	27514	27880	29898	31775	49507
22610	23530	25215	27077	27350	27519	27881	29899	31780	49520
22612	23532	25320	27078	27356	27524	27888	29904	31781	49521
22614	23550	25332	27090	27357	27535	28420	29905	31785	49525
22800	23552	25370	27091	27358	27536	28445	29906	31786	49540
22802	23585	25375	27122	27360	27540	28446	29907	31805	49550
22804	23615	25390	27125	27364	27556	28555	29914	32035	49553

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22808	23616	25391	27130	27365	27557	28585	29915	32036	49555
22810	23630	25393	27132	27380	27558	28615	29916	32096	49557
22812	23660	25405	27134	27381	27566	28705	30125	32097	49591
22830	23670	25420	27137	27385	27590	28715	30160	32098	49592
22840	23680	25425	27138	27386	27612	28725	30410	32100	49593
22842	23800	25426	27140	27396	27620	28730	30430	32110	49594
22843	23802	25440	27146	27397	27625	28735	30435	32120	49595
22844	24006	25441	27147	27400	27626	28737	30450	32124	49596
22845	24134	25442	27151	27403	27632	28740	30460	32140	49600
22846	24138	25443	27156	27405	27634	28760	30462	32141	49605
22847	24140	25444	27158	27407	27637	28800	30540	32150	49606
22849	24149	25446	27161	27409	27638	29804	30545	32151	49610
22850	24150	25447	27170	27418	27645	29820	31075	32160	49611
22852	24152	25490	27181	27420	27646	29821	31080	32200	49613
22853	24155	25491	27187	27422	27647	29822	31081	32215	49614
22854	24341	25492	27226	27424	27650	29823	31084	32220	49615
22855	24342	25515	27227	27427	27654	29824	31085	32225	49616
22856	24361	25525	27228	27428	27676	29825	31086	32310	49617
22858	24362	25526	27236	27429	27698	29826	31087	32320	49618
22859	24363	25545	27244	27438	27702	29827	31205	32440	49621
22861	24366	25574	27245	27440	27703	29828	31225	32442	49622
22864	24370	25575	27248	27441	27705	29834	31230	32445	49623
22867	24371	25607	27253	27442	27709	29835	31295	32480	49650
22868	24400	25608	27254	27443	27712	29836	31296	32482	49651
22869	24410	25609	27258	27445	27715	29837	31300	32484	50250
23145	24420	25628	27259	27446	27720	29843	31360	32486	57295
23150	24430	25645	27267	27447	27722	29844	31365	32488	
23155	24435	25670	27268	27448	27724	29845	31367	32491	
23172	24470	25676	27269	27450	27725	29847	31368	32503	
23174	24498	25685	27280	27454	27740	29851	31370	32504	
23182	24515	25695	27282	27455	27742	29855	31375	32900	
23184	24516	25800	27284	27457	27745	29856	31380	33507	
23410	24545	25805	27286	27465	27758	29860	31382	33926	
23412	24546	25810	27290	27466	27759	29861	31390	35011	
23420	24575	25820	27295	27468	27814	29862	31395	44346	
23440	24579	25825	27303	27470	27822	29863	31400	46710	
23450	24586	25830	27310	27472	27823	29884	31420	46712	
23455	24587	27036	27329	27479	27826	29885	31590	47563	
23460	24615	27045	27331	27486	27827	29887	31601	49491	

Added:
22808
23616…31601
49491

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21.2.2 Mental Health Services

Effective for dates of service on or after 7/1/2023, a CRNP/PA must be associated with a psychologist or psychiatrist in order to provide and file claims for the following services: 90791-90792, 90832-90834, and 90836-90838.

The CRNP/PA must enroll one of three ways to provide the listed services in a mental health setting:

a. Enrolled under a billing group with an assigned provider type of 54 (Psychologist).

b. Enrolled under a billing group with an assigned provider specialty of 339 (Psychiatrist).

c. Collaborate with a Psychologist or Psychiatrist that is verified as an active provider according to the Alabama Board of Medical Examiners.

21.3 Prior Authorization and Referral Requirements

CRNP and PA 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 ACHN Program, refer to Chapter 40.

Some procedure codes are limited as EPSDT-referred services only. Those services require an EPSDT referral form in the patient's medical record. Refer to Appendix A, EPSDT, for more information on obtaining a referral through the EPSDT Program. Refer to Appendix E, Medicaid Forms, for a sample of the Alabama Medicaid Agency Referral Form (form 362).

21.4 Cost Sharing (Copayment)

The copayment amount for office visit* including crossovers is:

$3.90 for procedure codes reimbursed $50.01 and greater
$2.60 for procedure codes reimbursed between $25.01 and $50.00
$1.30 for procedure codes reimbursed between $10.01 and $25.00

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

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

If one of these CPT codes is applicable for your practice, then copay applies.

Copayment does not apply to services provided for pregnant women, nursing facility residents, recipients less than 18 years of age, emergencies, and family planning. Native American Indians that present an "active user letter"

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issued by Indian Health Services (IHS) will be exempt from the Medicaid required copayment.

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

21.5 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

CRNPs or PAs who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When filing a claim on paper, a CMS-1500 claim form is required. Medicare-related claims must be filed using the Medical Medicaid/Medicare-related Claim Form.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

21.5.1 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.

21.5.2 Diagnosis Codes

The *International Classification of Diseases - 10th Revision - Clinical Modification* (ICD-10-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the
American Medical Association, AMA Plaza 330 North Wabash Ave, Suite 39300 Chicago, IL 60611-5885, or 1-800-621-8335.

NOTE:

ICD-9 codes should be used for claims submitted with dates of service prior to or equal to 09/30/2015.

ICD-10 codes should be used for claims submitted with dates of service on/after 10/01/2015.

21.5.3 Procedure Codes and Modifiers

Injectable drug codes referenced in Appendix H, Alabama Medicaid Physician Administered Drugs, and all laboratory services, which are CLIA certified.

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

21.5.4 Place of Service Codes

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

POS Code	*Description*
02	Telemedicine Services
11	Office
12	Home
21	Inpatient Hospital
19, 22	Outpatient Hospital
23	Emergency Room - Hospital
25	Birthing Center
26	Military Treatment Facility
31	Skilled Nursing Facility or Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
54	Intermediate Care Facility/Mentally Retarded
71	State or Local Public Health Clinic
72	Rural Health Clinic

21.5.5 Required Attachments

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

- Claims With Third Party Denials

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

Refer to Section 5.8, Required Attachments, for more information on attachments.

21.6 For More Information

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

Resource	Where to Find It
CMS-1500 Claim Filing Instructions	Chapter 5
Medical Medicaid/Medicare-related Claim Filing Instructions	Chapter 5
Medical Necessity/Medically Necessary Care	Chapter 7
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N

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22

22 Independent Radiology

The policy provisions for radiology providers can be found in the *Alabama Medicaid Agency Administrative Code,* Chapter 34.

22.1 Enrollment

Alabama Medicaid's Fiscal Agent enrolls Independent Radiology providers and issues provider contracts to applicants who meet the licensure and certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code*, and the *Alabama Medicaid Provider Manual*.

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

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

National Provider Identifier, Type, and Specialty

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

NOTE:
The 10-digit NPI is required when filing a claim.

Independent Radiology providers are assigned a provider type of 29 (Independent Radiology). Valid specialties for Independent Radiology providers include the following:

- 292 Mammography
- 327 Nuclear Medicine Practitioner
- 570 Physiological Lab (Independent Diagnostic Testing Facility)
- 291 Portable X Ray Clinic
- 290 Free Standing X-Ray
- 021 Cardiac Electrophysiology
- 996 Nuclear Medicine in an Independent Radiology
- 341 Radiologist
- 995 Radiology Clinic (CRS)

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- 312 Cardiologist
- 326 Neurologist

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
- 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. Refer to Chapter 7, Understanding Your Rights and Responsibilities as a Provider, for general criteria on Medical Necessity/ Medically Necessary Care

Radiology services are professional and technical radiological services, ordered and provided under the direction of a physician or other licensed practitioner of the healing arts. Within the scope of his practice as defined by state law and are provided in an office or similar facility other than an outpatient department of a hospital or clinic and meets the requirements for participation in Medicare. Radiology services are restricted to those that are described by procedures in the CPT manual. Providers will be paid only for covered services, which they actually perform.

NOTE:

PAs for radiation treatment and/ or management services must be requested within 30 days of providing the service. Refer to chapter 4 and 28 for more information.

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 77065 and 77066.

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 40 through 64. This screening should be billed under procedure codes 77067.

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Beginning on January 1, 2015, the complete examination is reported with code 76641 Ultrasound, breast, unilateral, real time with image documentation. Code 76641 represents a complete ultrasound examination of the breast. Code 76641 consists of an ultrasound examination of all four quadrants of the breast and the retroareolar region. It also includes ultrasound examination of the axilla, if performed. The limited code, 76642, is for a focused exam of the breast that is limited to one or more of the elements included in 76641. (e.g., a focused examination limited to one or more elements of 76641, but not all four). You may report either 76641 or 76442 once, per breast, per session. Both codes are unilateral: If medical necessity requires bilateral imaging, you may append modifier 50 Bilateral procedure.

Code	Description
76641	Ultrasound, breast, unilateral, real time with image documentation, including axilla when performed; complete
76642	Ultrasound, breast unilateral, real time with image documentation, including axilla when performed; limited

As with all ultrasound examinations, there must be a thorough evaluation of the anatomic area, image documentation, and a final written report to ensure that it is separately reportable. When performing a screening examination, list the screening diagnosis first, regardless of the finding or procedure perform due to the outcome of the screening. An ultrasound screening examination of the breast should be reported with:

- ICD-10 code Z12.39 (Encounter for other screening for malignant neoplasm of breast)

An Independent Radiology provider may bill for obstetrical ultrasounds. Ultrasound payment is limited to one per day. Effective 10/1/2019, Medicaid no longer requires prior authorization for obstetrical ultrasounds. All ultrasounds must be medically necessary with medical diagnosis documented supporting the benefit of the ultrasound procedure. DHCPs should refer to Chapter 40 for details regarding care coordination.

Nerve Conduction Studies and Electromyography

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

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

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

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

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

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

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

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

Limitations

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

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

- Safe and effective.

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

Documentation Requirements

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

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

- In the event of a review for medical necessity, the patient's medical record must support the need for the studies performed. The number of limbs or areas tested should be the minimum needed to evaluate the patient's condition. Repeat testing should be infrequent; limitation of testing services will be determined on the basis of individual medical necessity.
- Documentation addressing the need to evaluate the patient for peripheral neuropathy must be maintained by the practitioner and available upon request.
- Documentation addressing the indications and circumstances requiring individual nerve conduction studies (without accompanying EMG) must be maintained by the practitioner and made available upon request.

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- Credentials of providers billing for needle electromyography must be made available on request. According to the AANEM American Association of Neuromuscular & Electrodiagnostic Medicine, the EMG must be performed and interpreted by a physician who received training during residency and/or in special EDX fellowships after residency. Knowledge of EDX medicine is necessary to pass the board exams given by the American Board of Physical Medicine and Rehabilitation and the American Board of Psychiatry and Neurology.
- The NCS may be performed by a physician or by a trained allied health professional under direct supervision of a physician trained in electrodiagnostic medicine; although always interpreted by a credentialed physician.
- The record must reflect the need for EMG to localize the optimal injection site for the botulinum toxin.

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

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

NOTE:

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

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22.3 Prior Authorization (PA) and Referral Radiology Services

A PA is required for all MRI's, MRA's, CT scans, CTA's, and PET scans. Prior Authorization represents a clinical decision regarding medical necessity but is not a guarantee of payment.

The PA requirements will apply to Medicaid recipients who have **full** Medicaid eligibility as defined in Chapter 3, Verifying Recipient Eligibility.

Inpatient hospital, emergency room, Plan First, SOBRA Adult, and Medicaid/Medicare recipients are exempt from the PA requirement.

Send PA requests for outpatient diagnostic imaging procedures to eviCore by:

- Phone at (855) 774-1318
- Fax at (888) 693-3210
- Website at www.evicore.com.

(Normal business hours for phone or fax are 7:00 a.m. to 8:00 p.m. central time)

Only the referring provider and the performing provider may request a PA from eviCore.

Medicaid does not accept PAs from third party insurers. If the recipient has third party insurance, the provider must obtain a PA from Medicaid.

A provider must obtain a PA before performing a service. The requesting and performing providers will receive notification of the status for the requested PA. If additional information is required, the provider will have fifteen (15) calendar days from the original request date to provide this information. If no information is provided, the PA will be denied.

In the event of urgent care (services furnished within 12 hours to avoid the likely onset of an emergency medical condition) and the PA cannot be obtained prior to performing the test, the provider has thirty (30) calendar days from the date the test was performed to submit a request. This criterion is necessary for consideration of a PA. PA request with approval receives a valid authorization number. **The authorization number will be valid for sixty days from the approval date, not the date of the request.**

For simple changes such as modifier(s), use Form 471 (Prior Authorization Change Request). This applies only to approved PAs or PA requests in evaluation status. See Appendix E for Form 471. **This form is not for reconsiderations of denied PAs or for procedure code changes**. **If changing a procedure code, void the approved PA and submit a new PA request**.

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NOTE:

It is the responsibility of all providers to verify the approval of the PA before performing the service. Alabama Medicaid requires a prior authorization even when the recipient has a third party insurance.

In the event of retroactive eligibility, the retro date must cover the date of service. Providers have ninety (90) calendar days from the retro issue date to submit a written request indicating the recipient has been awarded retro eligibility and an error free red drop ink claim form, with medical documentation to:
Alabama Medicaid
Attn: Medical Services Division
501 Dexter Avenue
Montgomery, Alabama 36103-5624

PA is required for the following radiology codes:

PET SCANS
78459 Myocardial -metabolic
78491 Myocardial-single-rest/stress
78492 Myocardial, perfusion-multi
78608 Brain-metabolic
78609 Brain, perfusion
78811 Limited area
78812 Skull base to mid-thigh
78813 Whole body
78814 w/CT; limited area
78815 w/CT skull base to mid-thigh
78816 w/CT full body
CTA
70496 Head
70498 Neck
71275 Chest (non-coronary)
73206 Upper extremity
73706 Lower extremity
75635 CT Angio Abdominal Arteries
CT
70450 Head/brain w/o contrast
70460 Head/brain w/ contrast
70470 Head/brain w/o & w/contrast
70480 Orbit w/o contrast
70481 Orbit w/ contrast
70482 Orbit w/o & w/contrast
70486 Maxllfcl w/o contrast

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70487 Maxllfcl w/ contrast
70488 Maxllfcl w/o & w/contrast
70490 Soft tissue neck w/o contrast
70491 Soft tissue neck w/o, w/contrast
70492 Soft tissue neck w/o & w/contrast
71250 Thorax w/o contrast
71260 Thorax w/contrast
71270 Thorax w/o & w/contrast
72125 C-spine w/o contrast
72126 C-spine w/contrast
72127 C-spine w/o & w/contrast
72128 T-spine w/o contrast
72129 T- spine w/contrast
72130 T-spine w/ & w/o contrast
72131 L-spine w/o contrast
72132 L-spine w/contrast
72133 L-spine w/o & w/ contrast
72192 Pelvis w/o contrast
72191 CT Angiograph Pelv W/O&W/Dye
72193 Pelvis w/contrast
72194 Pelvis w/o & w/ contrast
73200 UE- w/o contrast
73201 UE- w/contrast
73202 UE w/o & with contrast
73700 LE w/o contrast
73701 LE w/ contrast
73702 LE w/o & w/contrast
74150 Abdomen w/o contrast
74160 Abdomen w/contrast
74170 Abdome w/o & w/contrast
74174 CT Angio Abd & Pelv W/O&W/Dye
74176 Abdomen & Pelvis w/o contrast
74177 Abdomen & Pelvis with contrast
74178 Abdomen & Pelvis; w/o & w/contrast
75571 Heart w/o contrast.
75572 Heart with contrast.
75573 Heart with contrast, in the setting of CHD.
75574 Heart CT Angiography.
76380 Limited or localized f/u study
77078 CT Bone Density Axial

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MRA
70544 Head w/o contrast
70545 Head w/contrast
70546 Head w/ & w/o contrast
70547 Neck w/o contrast
70548 Neck w/contrast
70549 Neck w/o & w/contrast
71555 Chest w/ or w/o contrast
72198 Pelvis w/ or w/o contrast
73225 UE w/ or w/o contrast
73725 LE w/ or w/o contrast
74174 CTA, Abdomen and pelvis with contrast
74185 Abdomen w/ or w/o contrast
MRI
70540 Face, orbit, &/or neck w/o contrast
70542 Face orbit &/or neck w & w/o cont.
70543 Face, orbit, &/or neck w & w/o cont.
70551 Brain w/o contrast
70552 Brain w/ contrast
70553 Brain w/& w/o contrast
71550 Chest w/o contrast
71551 Chest w/ contrast
71552 Chest w & w/o contrast
72141 C-spine w/o contrast
72142 C-spine w/contrast
72146 T-spine w/o contrast
72147 T-spine w/contrast
72148 L-spine w/o contrast
72149 L spine w/contrast
72156 c-spine w/ & w/o contrast
72157 T-spine w/ & w/o contrast
72158 L-spine w/ & w/o contrast
72195 Pelvis w/o contrast
72196 Pelvis w/ contrast
72197 Pelvis w/&w/o contrast
73218 UE w/o contrast
73219 UE w/contrast
73220 UE w/& w/o contrast
73221 UE joint w/o contrast
73222 UE joint w/contrast

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73223 UE joint w/& w/o contrast
73718 LE w/o contrast
73719 LE w/ contrast
73720 LE w/ & w/o contrast
73721 LE joint w/o contrast
73722 LE joint w/ contrast
73723 LE joint w & w/o contrast
74181 Abdomen w/o contrast
74182 Abdomen w/contrast
74183 Abdomen w & w/o contrast
75557 Cardiac w/o contrast
77046 MRI of one breast
77047 MRI of both breast
77048 MRI of one breast with and without contrast
77049 MRI of both breast with and without contrast

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22.4 Prior Authorization (PA) and Referral Requirements Cardiology Services

A PA is required for all Nuclear Cardiology, Diagnostic Heart catheterization, Stress Test (ECHO), Transesophageal Echo, and Transthoracic Echo. A prior authorization represents a clinical decision regarding medical necessity but is not a guarantee of payment.

The PA requirements will apply to Medicaid recipients who have full Medicaid eligibility as defined in Chapter 3 Verifying Recipient Eligibility.

Inpatient hospital, emergency room, Plan First, SOBRA Adults, and Medicaid/ Medicare recipients are exempt from the PA requirement.

Send PA requests for outpatient diagnostic imaging procedures to eviCore by:

- Phone at (855) 774-1318
- Fax at (888) 693-3210
- Website at www.evicore.com.

(Normal business hours for phone or fax are 7:00am to 8:00pm central time)

Only the referring provider and the performing provider may request a PA from eviCore.

Medicaid does not accept PAs from third party insurers. If a recipient has third party insurance, the provider must obtain a PA from Medicaid.

A provider must obtain a PA before performing a test. The requesting and performing providers will receive notifications of the status for the requested PA. If additional information is required, the provider will have fifteen (15) calendar days from the original request date to provide this information. If no information is provided, the PA will be denied.

In the event of urgent care (services furnished within 12 hours to avoid the likely onset of an emergency medical condition) and the PA cannot be obtain prior to performing the test, the provider has thirty (30) calendar days to submit a request from the date the test was performed. This criterion is necessary for consideration. PA request with approval receives a valid authorization number. The authorization number will be valid for sixty days from the approval date, not the date of the request.

For simple changes such as modifier(s), use Form 471 (Prior Authorization Change Request). This applies only to approved PAs or PA requests in evaluation status. See Appendix E for Form 471. This form is not for reconsiderations of denied PAs or for procedure code changes. If changing a procedure code, void the approved PA and submit a new PA request.

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NOTE:

It is the responsibility of all providers to verify the approval of the PA before performing the service. Alabama Medicaid requires a prior authorization even when the recipient has a third party insurance.

In the event of retroactive eligibility, the retro date must cover the date of service. Providers have ninety (90) calendar days from the retro issue date to submit a written request indicating the recipient has been awarded retro eligibility, and an error free drop ink claim form with medical documentation to:

Alabama Medicaid
Attn: Medical Services Division
501 Dexter Avenue
Montgomery, Alabama 36103-5624

PA is required for the following cardiology codes:

HEART CATHERIZATION
93451 RIGHT HEART CATHETERIZATION INCLUDING MEASUREMENT(S) OF OXYGEN SATURATION AND CARDIAC OUTPUT, WHEN PERFORMED.
93452 LEFT HEART CATHETERIZATION INCLUDING INTRAPROCEDURAL INJECTION(S) FOR LEFT VENTRICULOGRAPHY, IMAGING SUPERVISION AND INTERPRETATION, WHEN PERFORMED
93453 COMBINED RIGHT AND LEFT HEART CATHETERIZATION INCLUDING INTRAPROCEDURAL INJECTION(S) FOR LEFT VENTRICULOGRAPHY, IMAGING SUPERVISION AND INTERPRETATION, WHEN PERFORMED
93454 CATHETER PLACEMENT IN CORONARY ARTERY(S) FOR CORONARY ANGIOGRAPHY, INCLUDING INTRAPROCEDURAL INJECTION(S) FOR CORONARY ANGIOGRAPHY, IMAGING SUPERVISION AND INTERPRETATION;
93455 CATHETER PLACEMENT IN CORONARY ARTERY(S) FOR CORONARY ANGIOGRAPHY, INCLUDING INTRAPROCEDURAL INJECTION(S) FOR CORONARY ANGIOGRAPHY, IMAGING SUPERVISION AND INTERPRETATION; WITH CATHETER PLACEMENT(S) IN BYPASS GRAFT(S) (INTERNAL MAMMARY, FREE ARTERIAL, VENOUS GRAFTS) INCLUDING INTRAPROCEDURAL INJECTION(S) FOR BYPASS GRAFTANGIOGRAPHY
93456 CATHETER PLACEMENT IN CORONARY ARTERY(S) FOR CORONARY ANGIOGRAPHY, INCLUDING INTRAPROCEDURAL INJECTION(S) FOR CORONARY ANGIOGRAPHY, IMAGING SUPERVISION AND INTERPRETATION; WITH RIGHT HEART CATHETERIZATION
93457 CATHETER PLACEMENT IN CORONARY ARTERY(S) FOR CORONARY ANGIOGRAPHY, INCLUDING INTRAPROCEDURAL INJECTION(S) FOR CORONARY ANGIOGRAPHY, IMAGING SUPERVISION AND INTERPRETATION; WITH CATHETER PLACEMENT(S) IN BYPASS GRAFT(S) (INTERNAL MAMMARY, FREE ARTERIAL, VENOUS GRAFTS) INCLUDING INTRAPROCEDURAL INJECTION(S) FOR BYPASS GRAFT ANGIOGRAPHY AND RIGHT HEART CATHETERIZATION
93458 CATHETER PLACEMENT IN CORONARY ARTERY(S) FOR CORONARY ANGIOGRAPHY, INCLUDING INTRAPROCEDURAL INJECTION(S) FOR CORONARY ANGIOGRAPHY, IMAGING SUPERVISION AND INTERPRETATION; WITH LEFT HEART CATHETERIZATION INCLUDING INTRAPROCEDURAL INJECTION(S)

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93459 CATHETER PLACEMENT IN CORONARY ARTERY(S) FOR CORONARY ANGIOGRAPHY, INCLUDING INTRAPROCEDURAL INJECTION(S) FOR CORONARY ANGIOGRAPHY, IMAGING SUPERVISION AND INTERPRETATION; WITH LEFT HEART CATHETERIZATION INCLUDING INTRAPROCEDURAL INJECTION(S) FOR LEFT VENTRICULOGRAPHY, WHEN PERFORMED, CATHETER PLACEMENT(S) IN BYPASS GRAFT(S) (INTERNAL MAMMARY, FREE ARTERIAL, VENOUS GRAFTS) WITH BYPASS GRAFT ANGIOGRAPHY
93460 CATHETER PLACEMENT IN CORONARY ARTERY(S) FOR CORONARY ANGIOGRAPHY, INCLUDING INTRAPROCEDURAL INJECTION(S) FOR CORONARY ANGIOGRAPHY, IMAGING SUPERVISION AND INTERPRETATION; WITH RIGHT AND LEFT HEART CATHETERIZATION INCLUDING INTRAPROCEDURAL INJECTION(S) FOR LEFT VENTRICULOGRAPHY, WHEN PERFORMED
93461 CATHETER PLACEMENT IN CORONARY ARTERY(S) FOR CORONARY ANGIOGRAPHY, INCLUDING INTRAPROCEDURAL INJECTION(S) FOR CORONARY ANGIOGRAPHY, IMAGING SUPERVISION AND INTERPRETATION; WITH RIGHT AND LEFT HEART CATHETERIZATION INCLUDING INTRAPROCEDURAL INJECTION(S) FOR LEFT VENTRICULOGRAPHY, WHEN PERFORMED, CATHETER PLACEMENT(S) IN BYPASS GRAFT(S) (INTERNAL MAMMARY, FREE ARTERIAL, VENOUS GRAFTS) WITH BYPASS GRAFT ANGIOGRAPHY
NUCLEAR CARDIOLOGY
78451 MYOCARDIAL PERFUSION IMAGING, TOMOGRAPHIC (SPECT) (INCLUDING ATTENUATION CORRECTION, QUALITATIVE OR QUANTITATIVE WALL MOTION, EJECTION FRACTION BY FIRST PASS OR GATED TECHNIQUE, ADDITIONAL QUANTIFICATION, WHEN PERFORMED); SINGLE STUDY, AT REST OR STRESS (EXERCISE OR PHARMACOLOGIC)
78452 MYOCARDIAL PERFUSION IMAGING, TOMOGRAPHIC (SPECT) (INCLUDING ATTENUATION CORRECTION, QUALITATIVE OR QUANTITATIVE WALL MOTION, EJECTION FRACTION BY FIRST PASS OR GATED TECHNIQUE, ADDITIONAL QUANTIFICATION, WHEN PERFORMED); MULTIPLE STUDIES, AT REST AND/OR STRESS (EXERCISE OR PHARMACOLOGIC) AND/OR REDISTRIBUTION AND/OR REST REINJECTION
78453 MYOCARDIAL PERFUSION IMAGING, PLANAR (INCLUDING QUALITATIVE OR QUANTITATIVE WALL MOTION, EJECTION FRACTION BY FIRST PASS OR GATED TECHNIQUE, ADDITIONAL QUANTIFICATION, WHEN PERFORMED); SINGLE STUDY, AT REST OR STRESS (EXERCISE OR PHARMACOLOGIC)
78454 MYOCARDIAL PERFUSION IMAGING, PLANAR (INCLUDING QUALITATIVE OR QUANTITATIVE WALL MOTION, EJECTION FRACTION BY FIRST PASS OR GATED TECHNIQUE, ADDITIONAL QUANTIFICATION, WHEN PERFORMED); MULTIPLE STUDIES, AT REST AND/OR STRESS (EXERCISE OR PHARMACOLOGIC) AND/OR REDISTRIBUTION AND/OR REST REINJECTION
STRESS ECHO
93350 ECHOCARDIOGRAPHY, TRANSTHORACIC, REAL-TIME WITH IMAGE DOCUMENTATION (2D), INCLUDES M-MODE RECORDING, WHEN PERFORMED, DURING REST AND CARDIOVASCULAR STRESS TEST USING TREADMILL, BICYCLE EXERCISE AND/OR PHARMACOLOGICALLY INDUCED STRESS, WITH INTERPRETATION AND REPORT;
93351 ULTRASOUND EXAMINATION AND CONTINUOUS MONITORING OF THE HEART PERFORMED DURING REST, EXERCISE, AND/OR DRUG-INDUCED STRESS WITH INTERPRETATION AND REPORT 93352 INJECTION OF X-RAY CONTRAST MATERIAL FOR ULTRASOUND EXAMINATION OF THE HEART

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TRANSESOPHAGEAL ECHO
93312 ECHOCARDIOGRAPHY, TRANSESOPHAGEAL, REAL-TIME WITH IMAGE DOCUMENTATION (2D) (WITH OR WITHOUT M-MODE RECORDING); INCLUDING PROBE PLACEMENT, IMAGE ACQUISITION, INTERPRETATION AND REPORT
93313 ECHOCARDIOGRAPHY, TRANSESOPHAGEAL, REAL-TIME WITH IMAGE DOCUMENTATION (2D) (WITH OR WITHOUT M-MODE RECORDING); PLACEMENT OF TRANSESOPHAGEAL PROBE ONLY
93314 ECHOCARDIOGRAPHY, TRANSESOPHAGEAL, REAL-TIME WITH IMAGE DOCUMENTATION (2D) (WITH OR WITHOUT M-MODE RECORDING); IMAGE ACQUISITION, INTERPRETATION AND REPORT ONLY
TRANSTHORACIC ECHO
93303 TRANSTHORACIC ECHOCARDIOGRAPHY FOR CONGENITAL CARDIAC ANOMALIES; COMPLETE
93304 TRANSTHORACIC ECHOCARDIOGRAPHY FOR CONGENITAL CARDIAC ANOMALIES; FOLLOW-UP OR LIMITED STUDY
93306 ECHOCARDIOGRAPHY, TRANSTHORACIC, REAL-TIME WITH IMAGE DOCUMENTATION (2D), INCLUDES M-MODE RECORDING, WHEN PERFORMED, COMPLETE, WITH SPECTRAL DOPPLER ECHOCARDIOGRAPHY, AND WITH COLOR FLOW DOPPLER ECHOCARDIOGRAPHY
93307 ECHOCARDIOGRAPHY, TRANSTHORACIC, REAL-TIME WITH IMAGE DOCUMENTATION (2D), INCLUDES M-MODE RECORDING, WHEN PERFORMED, COMPLETE, WITHOUT SPECTRAL OR COLOR DOPPLER ECHOCARDIOGRAPHY
93308 ECHOCARDIOGRAPHY, TRANSTHORACIC, REAL-TIME WITH IMAGE DOCUMENTATION (2D), INCLUDES M-MODE RECORDING, WHEN PERFORMED, FOLLOW-UP OR LIMITED STUDY INJECTION, PERFLUTREN LIPID MICROSPHERES, PERML

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22.5 Cost Sharing (Copayment)

Copayment amount does not apply to services provided by Independent Radiology providers.

22.6 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, provider should bill Medicaid claims electronically.

Radiology providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When filing a paper claim, a CMS-1500 claim form is required. Medicare-related claims must be filed using the Medical Medicaid/Medicare-related Claim Form 340. All paper claims must be a one page error free red drop ink form.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

22.6.1 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 Chapter 5, Filing Claims, for more information regarding timely filing limits and exceptions.

22.6.2 Diagnosis Codes

For dates of service 01/01/99 and after valid diagnosis codes are required. The International Classification of Diseases - 10th Revision - Clinical Modification (ICD-10-CM) manual lists Medicaid required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, AMA Plaza 330 North Wabash Ave, Suite 39300 Chicago, IL 60611-5885, or 1-800-621-8335.

For dates of service prior to 01/01/99, Independent Radiology providers are not required to provide valid diagnosis codes. Providers must bill diagnosis ICD 10 Z01.89 on hard copy and electronically submitted claims.

NOTE:

ICD-10 codes should be used for claims submitted with dates of service on/after 10/01/2015.

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NOTE:

ICD-10 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

22.6.3 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, P. O. Box 930876 Atlanta, GA 31193-0873 or 1-800-621-8335.

Radiology Facilities are limited to billing CPT radiology procedure codes. The range of codes is 70010 through 79999. Physiological labs are restricted to the codes listed in their contract with Medicaid.

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

Professional and Technical Components

Some procedure codes in the 70000 and 90000, and G series are a combination of a professional component and a technical component. Therefore, these codes may be billed three different ways; (1) as a global, (2) as a professional component, or (3) as a technical component.

- **Global**, the provider must own the equipment, pay the technician, review the results, and provide a written report of the findings. The procedure code is billed with no modifiers.
- **Professional component**, the provider does not own the equipment. The provider operates the equipment and/or reviews the results, and provides a written report of the findings. The Radiological professional component is billed by adding modifier 26 to the procedure code, and should be billed only for the following place of service locations:
- **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.

22.6.4 Place of Service Codes

Radiology service claims may be filed using, but not limited to, the following place of service:

POS Code	*Description*
11	Clinic

22.6.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to claims with third party denials.

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NOTE:
When an attachment is required, submit a hard copy error free red drop ink form.

Refer to Chapter 5, for more information on required attachments.

22.7 For More Information

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

Resource	Where to Find It
CMS-1500 Claim Filing Instructions	Chapter 5
Medical Medicaid/Medicare-related Claim Filing Instructions	Chapter 5
Medical Necessity/Medically Necessary Care	Chapter 7
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N
Medicaid Forms	Appendix E

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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

Gainwell enrolls Licensed Social Workers and issues provider contracts to applicants who meet the licensure and certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code*, and the *Alabama Medicaid Provider Manual*.

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

National Provider Identifier, Type, and Specialty

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

NOTE:
The 10-digit NPI is required when filing a claim.

Licensed Social Workers are assigned a provider type of 11 (Crossovers Only). The valid specialty for Licensed Social Workers is Medicare/Medicaid Crossover Only 116.

Enrollment Policy for Licensed Social Workers

To participate in the Alabama Medicaid Program, Licensed Social Workers must meet the following requirements:

- Possess certification as a Medicare provider
- Possess current certification as a licensed social worker from the Board of Social Work Examiners

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

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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. Refer to Chapter 7, Understanding Your Rights and Responsibilities as a Provider, for general criteria on Medical Necessity/ Medically Necessary Care

Licensed Social Workers are limited to crossover claims for those services to QMB recipients only.

23.3 Prior Authorization and Referral Requirements

Prior Authorization and referral requirements do not apply to Licensed Social Workers because all services are limited to Medicare crossover claims.

23.4 Cost Sharing (Copayment)

Copayment does not apply to Licensed Social Workers.

23.5 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

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.

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23.5.2 Diagnosis Codes

The *International Classification of Diseases - 10th Revision - Clinical Modification* (ICD-10-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, AMA Plaza 330 North Wabash Ave, Suite 39300 Chicago, IL 60611-5885, or 1-800-621-8335.

NOTE:

ICD-9 codes should be used for claims submitted with dates of service prior to or equal to 09/30/2015.

ICD-10 codes should be used for claims submitted with dates of service on/after 10/01/2015.

NOTE:

ICD-9 or ICD-10 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

23.5.3 Procedure Codes and Modifiers

When filing Medicare/Medicaid crossovers, be sure to use the same procedure codes and modifiers as filed to Medicare. The (837) Professional, Institutional and Dental electronic claims and the paper claim have been modified to accept up to four Procedure Code Modifiers.

23.5.4 Place of Service Codes

When filing Medicare/Medicaid crossovers, be sure to use the same place of service code as filed to Medicare.

23.5.5 Required Attachments

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

- Claims With Third Party Denials

NOTE:

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

Refer to Section 5.8, Required Attachments, for more information on attachments.

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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	Chapter 5
Medical Necessity/Medically Necessary Care	Chapter 7
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
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24 Maternity Care Program

Chapter 24, Maternity Care Program has been removed from this Provider Manual. The Maternity Care Program transitioned to the Alabama Coordinated Health Network (ACHN) on October 1, 2019.

Refer to Chapter 40 for the “Alabama Coordinated Health Network (ACHN), Primary Care Physician (PCP), and Delivering Healthcare Professional (DHCP) Billing”.

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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

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

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

National Provider Identifier, Type, and Specialty

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

NOTE:
The 10-digit NPI is required when filing a claim.

Nurse Midwives are assigned a provider type of 09 (Other).The valid specialty for nurse midwives is Nurse Midwife (095).

Enrollment Policy for Nurse Midwives

Providers in this program must possess a license as a Registered Nurse and also a license as a Certified Nurse Midwife.

Nurse midwives must submit the following documents for participation in Medicaid:

- Copy of the current licensure or licensure renewal card
- Copy of the American Midwifery Certification Board (AMCB) certificate
- Copy of the Certified Nurse Midwifery Protocol signed by your collaborating physician

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- Letter from the hospital outlining what functions a certified nurse midwife takes during patient admissions and/or 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. Refer to Chapter 7, Understanding Your Rights and Responsibilities as a Provider, for general criteria on Medical Necessity/ Medically Necessary Care. Refer to Chapter 40, Alabama Coordinated Health Network (ACHN)—Primary Care Physician (PCP) and Delivering Healthcare Professional (DHCP) Billing, for more details.

Medicaid bases reimbursement of services on a fee for service for the procedure codes covered for nurse midwife providers.

The services provided by nurse midwives must be within the scope of practice authorized by state law and regulations. Alabama law provides rules under which properly trained nurses can be licensed to practice Nurse Midwifery. Federal law requires that Medicaid include the services of nurse midwives.

A hospital-based nurse midwife who is employed with and paid by a hospital may not bill Medicaid for services performed at the hospital and for which the hospital is reimbursed.

A nurse midwife who is not employed with and paid by a hospital may bill Medicaid using a CMS-1500 claim form.

25.2.1 Covered Services

The maternity services normally provided in maternity cases include antepartum care, delivery, and postpartum care. When a nurse midwife provides total obstetrical care, the claim form should reflect the procedure code for all-inclusive "global" care. The indicated date of service on "global" claims should be the date of delivery.

When a nurse midwife provides eight or more prenatal visits, performs the delivery, and provides postpartum care, the midwife uses a "global" obstetrical code in billing the services. If a nurse midwife submits a "global" code for maternity services, the visits covered by this code are not counted against the recipient's limit of physician office visits per calendar year. For purposes of "global" obstetrical billing, services rendered by members of a group practice are to be considered as services rendered by a single provider.

If a woman is pregnant at the time she becomes eligible for Medicaid benefits, only those services provided during the time that she is eligible are covered.

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NOTE:

Effective November 1, 2015, Medicaid SOBRA (Pregnant Women) recipients, who were once eligible for pregnancy-related services ONLY may receive full Medicaid benefits throughout pregnancy and post-partum, whether the services were pregnancy related or not.
Claims that are pregnancy related will require a pregnancy related diagnosis code or a postpartum diagnosis code. Co-pays may be applied for services that are non-pregnancy related. A recipient's age, health care requirements, and place of residence may further define his or her eligibility for Medicaid covered services. For this reason, it is very important that the providers verify recipient eligibility and ensure they understand all aspects of the eligibility response. Eligibility responses have been changed to reflect the correct coverage for these women.

Services provided that are not pregnancy-related may be billed fee-for-service by a provider. A recipient's age, health care requirements, and place of residence may further define his or her eligibility for Medicaid covered services. For this reason, it is very important that the providers verify recipient eligibility and ensure they understand all aspects of the eligibility response. Eligibility responses have been changed to reflect the correct coverage for these women.

A provider may reference the fee schedules for a list of covered services on the following link:
http://medicaid.alabama.gov/content/Gated/7.3G_Fee_Schedules.aspx

The fee schedules are not an all-inclusive list of procedure codes covered by the Agency

Refer to Chapter 4, Obtaining Prior Authorization (PA) for PA requirements.

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

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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 12 months after delivery. Additional claims for routine visits during this time should not be filed. Family planning services performed by the delivering provider on the day of the postpartum exam or within five days of the postpartum exam are noncovered as they are included in the postpartum exam. The only exception to this is Extended Contraceptive Counseling visits, which are performed at the same time as the postpartum exam.

If the provider does not perform the delivery but does provide the postpartum care, family planning services rendered within five days of the postpartum exam are noncovered, as they are included in the postpartum exam.

Family Planning

Family planning services include services that prevent or delay pregnancy. Such services include office visits for evaluation and management of contraceptive issues, including procedures and supplies as appropriate for effective birth control. Nurse midwives are not authorized to perform sterilization procedures. Other surgical procedures such as diaphragm fittings, IUD insertions or removals, and contraceptive implant procedures, are covered when provided according to state laws and regulations.

The nurse midwife may be reimbursed for well-woman gynecological services including the evaluation and management of common medical or gynecological problems such as menstrual problems, Pap smear screenings, menopausal and hormonal treatments, treatment of sexually transmitted diseases, and treatment of minor illnesses (e.g., a minor pelvic inflammatory disease).

25.2.2 Required Written Records

When a patient is accepted for maternity services, the midwife's care must include plans to accomplish the delivery in a licensed hospital. In an emergency, delivery may be accomplished elsewhere. The plans need not be submitted to Medicaid, but the midwife's file should contain written evidence that such plans exist for each patient accepted for global care.

All nurse midwife services must be rendered under appropriate physician supervision. The physician may not bill for these supervisory services. Midwives' written records should include records naming the supervisory physician(s) and stating the working arrangement. The statement of the working arrangement need not be a formal contract, but it must contain the signature of both parties and must show the date on which it was signed.

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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 Alabama Coordinated Health Network (ACHN) Program, refer to Chapter 40, Alabama Coordinated Health Network ACHN—Primary Care Physician (PCP) and Delivering Healthcare Professional (DHCP) Billing, to determine whether your services require a referral from the Primary Care Physician (PCP).

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

The copayment does not apply to antepartum care, delivery, and postpartum care and family planning provided by nurse midwives. Copayments may be applied to services that are not pregnancy related. Copayments are required for well-woman gynecological services except for those recipients under the age of 18.

Nurse midwives providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions

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- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When filing a claim on paper, a CMS-1500 claim form is required.

This section describes program-specific claims information. Providers should refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

25.5.1 Time Limit for Filing Claims

Medicaid requires all claims for Nurse Midwife providers to be filed within one year of the date of service. Refer to Section 5.1.4, Filing Limits, for more information regarding timely filing limits and exceptions.

25.5.2 Diagnosis Codes

The *International Classification of Diseases - 10th Revision - Clinical Modification* (ICD-10-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, AMA Plaza 330 North Wabash Ave, Suite 39300 Chicago, IL 60611-5885, or 1-800-621-8335.

Family Planning diagnosis codes are in the Z30 category for ICD-10. A pregnancy or postpartum ICD-10 diagnosis code, primary or secondary, must be used when billing maternity care services.

NOTE:

ICD-10 codes should be used for claims submitted with dates of service on/after 10/01/2015.

NOTE:

ICD-10 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

25.5.3 Procedure Codes and Modifiers

Nurse midwife providers use the Current Procedural Terminology (CPT) coding system. The CPT manual lists most required procedure codes. This manual may be obtained by contacting the Order Department, American Medical Association, 515 North State Street, Chicago, IL 60610-9986.

Nurse Midwives are generally reimbursed at 80% of the allowed amount for all services except lab and injectables, which should pay at 100%.

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Nurse midwives may submit claims and receive reimbursements for the following services:

Family Planning

Nurse midwives may submit claims and receive reimbursements for Family Planning services, excluding sterilization procedures. See Appendix C, Family Planning, for these procedure codes. The (837) Professional and Institutional electronic claims and the paper claim have been modified to accept up to four Procedure Code Modifiers.

GYN Services

Nurse midwives may bill office procedure codes 99201-99233.

Maternity Care

Code	Modifier	*Procedure Description*
59400	U9	Routine obstetric care including antepartum care, vaginal delivery **(delivery at 39 weeks of gestation or later)** (with or without episiotomy or forceps) and postpartum care
59400	UD	Routine obstetric care including antepartum care, vaginal delivery **(medically necessary delivery prior to 39 weeks of gestation)** (with or without episiotomy or forceps) and postpartum care
59400	UC	Routine obstetric care including antepartum care, vaginal delivery **(non-medically necessary prior to 39 weeks of gestation)** (with or without episiotomy or forceps) and postpartum care
59409	U9	Vaginal delivery only (delivery at 39 weeks of gestation or later) (with or without episiotomy and/or forceps)
59409	UD	Vaginal delivery only (medically necessary delivery prior to 39 weeks of gestation) (with or without episiotomy and/or forceps)
59409	UC	Vaginal delivery only (non-medically necessary delivery prior to 39 weeks of gestation) (with or without episiotomy and/or forceps)
59410	U9	Vaginal delivery (delivery at 39 weeks of gestation or later) and postpartum care only
59410	UD	Vaginal delivery (medically necessary delivery prior to 39 weeks of gestation) and postpartum care only
59410	UC	Vaginal delivery (non-medically necessary prior to 39 weeks of gestation) and postpartum care only
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

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25.5.4 Place of Service Codes

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

POS	*Description*
21	Inpatient Hospital
11	Physician's Office
12	Patient's Home
22	Outpatient
23	ER-Hospital
25	Birthing Center

25.5.5 Required Attachments

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

- Claims With Third Party Denials

NOTE:

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

Refer to Section 5.8, 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
Obtaining Prior Authorization	Chapter 4
CMS-1500 Claim Filing Instructions	Chapter 5
Medical Necessity/Medically Necessary Care	Chapter 7
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N

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26 Nursing Facility

Medicaid reimburses medically necessary nursing facility services. Nursing facilities must meet the licensure requirements of the Alabama Department of Public Health and the certification requirements of Title XIX and XVIII of the Social Security Act and must comply with all applicable state and federal laws and regulations.

A nursing facility is an institution that primarily provides one of the following:

- Nursing care and related services for residents who require medical or nursing care
- Rehabilitation services for the rehabilitation of injured, disabled, or sick persons
- Health care and services to individuals who require a level of care available only through institutional facilities

A facility may not include any institution for the care and treatment of mental disease except for services furnished to individuals age 65 and over or any institutions for the mentally retarded or persons with related conditions.

The policy provisions for nursing facility providers can be found in the *Alabama Medicaid Agency Administrative Code,* Chapter 10, and Part 483 of the Code of Federal Regulations.

26.1 Enrollment

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

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

National Provider Identifier, Type, and Specialty

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

NOTE:
The 10-digit NPI is required when filing a claim.

Nursing facility providers are assigned a provider type of 03 (Nursing Facility). The valid specialty for nursing facility providers is Nursing Facility (035).

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Enrollment Policy for Nursing Facility Providers

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

- Possess certification for Medicare Title XVIII
- Submit a budget to the Provider Reimbursement Section at Medicaid for the purpose of establishing a per diem rate
- Execute a Provider Agreement and a Nursing Facility/Resident Agreement with Medicaid

The Provider Agreement details the requirements imposed on each party to the agreement. It is also the document that requires the execution of the Nursing Facility/Resident Agreement.

The Nursing Facility/Resident Agreement must be executed for each resident on admission and annually thereafter. If the liability amount changes for the resident or if there are policy changes, the agreement must be signed and dated as these changes occur. One copy of the agreement is given to the resident/personal representative and a copy is retained by the nursing facility. The completed Nursing Facility/Resident Agreement becomes an audit item by Medicaid.

Gainwell is responsible for enrolling all nursing facility providers including any Medicare certified nursing facilities who wish to enroll as a QMB Medicare only provider.

Renewal Process for Nursing Facilities

The Alabama Department of Public Health conducts annual recertification of all nursing facility providers and provides the recertification information to Medicaid.

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

Change of Ownership (CHOW) and Closures

Medicaid will mirror Medicare's Change of Ownership (CHOW) policy
Refer to Chapter 19, Hospital for additional information on Change of Ownership

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. Refer to Chapter 7, Understanding Your Rights and Responsibilities as a Provider, for general criteria on Medical Necessity/ Medically Necessary Care.

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.

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Nursing facilities must comply with Title VI of the Civil Rights Act of 1964, the Federal Age Discrimination Act, Section 504 of the Rehabilitation Act of 1973, and the Disabilities Act of 1990.

Nursing facilities must maintain identical policies and practices regarding transfer, discharge, and covered services for all residents regardless of source of payment.

Nursing facilities must have all beds in operation certified for Medicaid participation.

Nursing facilities must not require a third party guarantee of payment to the facility as a condition of admission, expedited admission, or continued stay in the facility.

Nursing facilities may require an individual who has legal access to a resident's income or available resources to sign a contract, without incurring personal financial liability, to provide facility payment from the resident's income or resources.

Covered Services

The following services are included in basic covered nursing facility charges:

- All nursing services to meet the total needs of the resident, including treatment and administration of medications ordered by the physician
- Personal services and supplies for the comfort and cleanliness of the resident. These include assistance with eating, dressing, toilet functions, baths, brushing teeth, combing hair, shaving and other services and supplies necessary to permit the resident to maintain a clean, well-kept personal appearance such as hair hygiene supplies, comb, brush, bath soap, disinfecting soaps or specialized cleansing agents when indicated to treat special skin problems or to fight infection, razors, shaving cream, toothbrush, toothpaste, denture adhesive, denture cleanser, dental floss, moisturizing lotion, tissues, cotton balls, cotton swabs, deodorant, incontinence supplies, sanitary napkins and related supplies, towels, washcloths, hospital gowns, hair and nail hygiene services, bathing, basic personal laundry and incontinence care.
- Room (semiprivate or ward accommodations) and board, including special diets and tube feeding necessary to provide proper nutrition. This service includes feeding residents unable to feed themselves.
- All services and supplies for incontinent residents, including diapers and linen savers
- Bed and bath linens
- Nursing and treatment supplies as ordered by the resident’s physician as required, including needles, syringes, catheters, catheter trays, drainage bags, indwelling catheters, enema bags, normal dressing, special dressings (such as ABD pads and pressure dressings), intravenous administration sets, and normal intravenous fluids (such as glucose, D5W, D10W)

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- Safety and treatment equipment such as bed rails, standard walkers, standard wheelchairs, intravenous administration stands, suction apparatus, oxygen concentrators and other items generally provided by nursing facilities for the general use of all residents
- Materials for prevention and treatment of bed sores
- Medically necessary over-the-counter (non-legend) drug products when ordered by a physician. Generic brands are required unless brand name is specified in writing by the physician
- OTC drugs are covered under the nursing facility per diem rate with the exception of insulin covered under the Pharmacy program

Non-covered Services

Special (non-covered) services, drugs, or supplies not ordinarily included in basic nursing facility charges may be provided by the nursing facility or by arrangement with other vendors by mutual agreement between the resident, or their personal representative and the nursing facility

- Prosthetic devices, splints, crutches, and traction apparatus for individual residents

If payment is not made by Medicare or Medicaid, the facility must inform the resident/personal representative that there will be a charge, and the amount of the charge. Listed below are general categories and examples of items:

- Telephone;
- Television/radio for personal use;
- Personal comfort items, including smoking materials, notions and novelties, and confections;
- Cosmetic and grooming items and services in excess of those for which payment is made under Medicaid or Medicare;
- Personal clothing;
- Personal reading matter;
- Gifts purchased on behalf of a resident;
- Flowers and plants;
- Social events and entertainment offered outside the scope of the required activities program;
- Noncovered special care services such as privately hired nurses or aides;
- Private room, except when therapeutically required (for example: isolation for infection control);
- Specially prepared or alternative foods request instead of the food generally prepared by the facility;
- Beauty and barber services provided by professional barbers and beauticians;
- Services of licensed professional physical therapist;
- Routine dental services and supplies;
- Tanks of oxygen.

Medicaid provides other services under separate programs, including prescription drugs as listed in the Alabama Drug Code Index, hospitalization, laboratory and x-ray services, and physician services.

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Payment for Reservation of Beds

Neither Medicaid residents, nor their families, nor their personal representative, may be charged for reservation of a bed for the first four days of any period during which a Medicaid resident is temporarily absent due to admission to a hospital. Prior to discharge of the resident to the hospital, the resident, the family of the resident, or the personal representative of the resident is responsible for making arrangements with the nursing home for the reservation of a bed and any costs associated with reserving a bed for the resident beyond the covered four-day hospital reservation period. The covered four-day hospital stay reservation policy does not apply to:

- Medicaid-eligible residents who are discharged to a hospital while their nursing home stay is being paid by Medicare or another payment source other than Medicaid;
- Any non-Medicaid residents;
- A resident who has applied for Medicaid but has not yet been approved; provided that if such a resident is later retroactively approved for Medicaid and the approval period includes some or all of the hospital stay, then the nursing home shall refund that portion of the bed hold reservation charge it actually received from the resident, family of the resident, or personal representative of the resident for the period that would have been within the four covered days policy; or
- Medicaid residents who have received a notice of discharge for non-payment of service.

NOTE:

HOLDING OF MEDICATIONS FOR LTC RESIDENTS

When a resident leaves a LTC facility and is expected to return, the facility shall hold all medications until the return of the resident. All continued or re-ordered medications will be placed in active medication cycles upon the return of the resident. If the resident does not return to the facility within 30 days, any medications held by the facility shall be placed with other medications for destruction or distribution as permitted by the State Board of Pharmacy regulations. If at the time of discharge it is known that the resident will not return, medications may be destroyed or donated as allowed by State law.

If the medications are not held on accordance with this policy, the facility will be responsible for all costs associated with replacement of the medication.

Therapeutic Visits

Payments to nursing facilities may be made for therapeutic leave visits to home, relatives, and friends for up to six days per calendar quarter. A therapeutic leave visit may not exceed three days per visit. A resident may have a therapeutic visit that is one, two, or three days in duration as long as the visit does not exceed three days per visit or six days per quarter. Visits may not be combined to exceed the three-day limit.

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The nursing facility must ensure that each therapeutically indicated visit by a resident to home, relatives, or friends is authorized and certified by a physician.

Payments to ICF/IID facilities for therapeutic visits are limited to 14 days per calendar month.

Medicaid is not responsible for the record-keeping process involving therapeutic leave for the nursing facility. Medicaid will track the use of therapeutic leave through the claims processing system.

The nursing facility must provide written notice to the resident and a family member or legal representative of the resident, specifying the Medicaid policy when a resident takes therapeutic leave and when a resident transfers to a hospital.

The nursing facility or ICF/IID must establish and follow a written policy under which a resident who has been hospitalized or who exceeds therapeutic leave policy is readmitted to the facility. Residents are readmitted immediately upon the first available bed in a semi-private room if the resident requires the services provided by the facility.

Residents with Medicare Part A

Medicaid may pay the Part A coinsurance for the 21st through the 100th day for Medicare/Medicaid eligible recipients who qualify under Medicare rules for skilled level of care.

An amount equal to that applicable to Medicare Part A coinsurance, but not greater than the facility's Medicaid rate will be paid for the 21st through the 100th day. Medicaid will make no payment for nursing care in a nursing facility for the first 20 days of care for recipients qualified under Medicare rules.

Nursing facilities must ensure that Medicaid recipients eligible for Medicare Part A benefits first use Medicare benefits before accepting a Medicare/Medicaid recipient as a Medicaid resident.

Residents who do not agree with adverse decisions regarding level of care determinations by Medicare should contact the Medicare fiscal intermediary.

Application of Medicare Coverage

Nursing facility residents, either through age or disability may be eligible for Medicare coverage up to 100 days.

Nursing facilities must apply for eligible Medicare coverage prior to Medicaid coverage.

Nursing facilities cannot apply for Medicaid eligibility for a resident until Medicare coverage is discontinued.

Periods of Entitlement

The earliest date of entitlement for Medicaid is the first day of the month of when the applicant meets all requirements for medical and financial eligibility.

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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.

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.

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. An applicant must be medically approved by Medicaid or Medicare prior to financial approval. For retroactive Medicaid coverage the determination of level of care will be made by the nursing facility's RN. The nursing facility should furnish the Long Term Care Division or its designee, a Form 161B, a Form 161, and the financial award letter for the retro period of time.

Nursing Aide Training

A nursing facility must not use (on a full-time, temporary, per diem, or other basis) any individual as a nurse aide in the facility for more than four months unless the individual has completed training and a competency evaluation program approved by the state.

The Alabama Department of Public Health is responsible for the certification of the Competency Evaluation programs and maintains a nurse aide registry.

Pre-admission Screening and Resident Review

Prior to admission, all individuals seeking admission into a nursing facility must be screened for suspected mental illness (MI), intellectual disability (ID), or a related condition (RC) to determine if the individual's care and treatment needs can most appropriately be met in the nursing facility or in some other setting.

A Level I Screening document (LTC-14) must be completed in its entirety and submitted to the OBRA PASRR Office for a Level I Determination prior to admission. The Level I Screening can be completed by anyone who has access to the medical records excluding family members.

The nursing facility is responsible for ensuring that the applicant is not admitted into the nursing facility without a Level I Screening, Level I Determination and Level II Determination, if applicable, from the Department of Mental Health. The nursing facility is responsible for ensuring that the Level I Determination is signed and dated by the RN indicating that the Level I Screening is accurate based on the available medical records.

The Department of Mental Health is responsible for conducting a Level II Evaluation on all applicants and residents with a suspected diagnosis of

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MI/ID/RC to determine the individual's need for mental health specialized services and medical eligibility. For all residents with a primary or secondary diagnosis of MI/ID, the Department of Mental Health will make the determination of appropriate placement in a nursing facility, based on the results of the Level II Screening and the application of Medicaid medical criteria.

If the nursing facility fails to obtain the Level I Screening, Level I Determination and Level II Determination, if applicable, made by the Department of Mental Health prior to admitting the resident into their facility, the Alabama Medicaid Agency will recoup all Medicaid payments for nursing facility services from the date of the resident's admission and continuing until the Level I Determination or Level II Determination, if applicable is received.

If a resident is discharged into the community for more than 30 days, a new Level I Screening, Level I Determination, and Level II Determination, if applicable, is required before admission.

If the nursing facility's interdisciplinary team identifies a significant change in the condition of a resident with a diagnosis of MI/ID/RC, an updated Level I Screening must be completed and submitted to the Department of Mental Health's PASRR Office within 14 days of the resident's status change to receive an updated Level II Determination to establish continued eligibility. If the nursing facility fails to update the Level I Screening for a significant change in a resident's condition, the Alabama Medicaid Agency may recoup all Medicaid payments for nursing facility services from 14 days of the resident's change in condition and continuing until the updated Level II Determination is received.

Admission Criteria

The principal aspect of covered care relates to the care rendered. The controlling factor in determining whether a person receives covered care is the medical supervision that the resident requires. Nursing facility care provides physician and nursing services on a continuing basis. The nursing services are provided under the general supervision of a licensed registered nurse. An individual may be eligible for nursing facility care under the following circumstances:

- The physician must certify the need for admission and continuing stay.
- The recipient requires nursing care on a daily basis.
- The recipient requires nursing services that as a practical matter can only be provided in a nursing facility on an inpatient basis.
- Nursing services must be furnished by or under the supervision of a RN and under the general direction of a physician.

A nursing care resident must require **two or more** of the following specific services:

a. Administration of a potent and dangerous injectable medication and intravenous medications and solutions on a daily basis or administration of routine oral medications, eye drops, or ointment
b. Restorative nursing procedures (such as gait training and bowel and bladder training) in the case of residents who are determined to have restorative potential and can benefit from the training on a daily basis

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c. Nasopharyngeal aspiration required for the maintenance of a clear airway
d. Maintenance of tracheostomy, gastrostomy, colostomy, ileostomy and other tubes indwelling in body cavities as an adjunct to active treatment for rehabilitation of disease for which the stoma was created
e. Administration of tube feedings by naso-gastric tube
f. Care of extensive decubitus ulcers or other widespread skin disorders
g. Observation of unstable medical conditions required on a regular and continuing basis that can only be provided by or under the direction of a registered nurse
h. Use of oxygen on a regular or continuing basis
i. Application of dressing involving prescription medications and aseptic techniques and/or changing of dressing in non-infected, post-operative, or chronic conditions
j. Comatose resident receiving routine medical treatment
k. Assistance with at least one of the activities of daily living below on an ongoing basis:

1. Transfer - The individual is incapable of transfer to and from bed, chair, or toilet unless physical assistance is provided by others on an ongoing basis (daily or multiple times per week).

2. Mobility - The individual requires physical assistance from another person for mobility on an ongoing basis (daily or multiple times per week). Mobility is defined as the ability to walk, using mobility aids such as a walker, crutch, or cane if required, or the ability to use a wheelchair if walking is not feasible. The need for a wheelchair, walker, crutch, cane, or other mobility aid shall not by itself be considered to meet this requirement.

3. Eating - The individual requires gastrostomy tube feedings or physical assistance from another person to place food/drink into the mouth. Food preparation, tray set-up, and assistance in cutting up foods shall not be considered to meet this requirement.

4. Toileting - The individual requires physical assistance from another person to use the toilet or to perform incontinence care, ostomy care, or indwelling catheter care on an ongoing basis (daily or multiple times per week).

5. Expressive and Receptive Communication - The individual is incapable of reliably communicating basic needs and wants (e.g., need for assistance with toileting; presence of pain) using verbal or written language; or the individual is incapable of understanding and following very simple instructions and commands (e.g., how to perform or complete basic activities of daily living such as dressing or bathing) without continual staff intervention.

6. Orientation - The individual is disoriented to person (e.g., fails to remember own name, or recognize immediate family members) or is disoriented to place (e.g., does not know residence is a Nursing Facility).

7. Medication Administration - The individual is not mentally or physically capable of self-administering prescribed medications despite the availability of limited assistance from another person. Limited

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assistance includes, but is not limited to, reminding when to take medications, encouragement to take, reading medication labels, opening bottles, handing to individual, and reassurance of the correct dose.

8. Behavior - The individual requires persistent staff intervention due to an established and persistent pattern of dementia-related behavioral problems (e.g., aggressive physical behavior, disrobing, or repetitive elopement attempts).

9. Skilled Nursing or Rehabilitative Services - The individual requires daily skilled nursing or rehabilitative services at a greater frequency, duration, or intensity than, for practical purposes, would be provided through a daily home health visit.

The above criteria should reflect the individual's capabilities on an ongoing basis and not isolated, exceptional, or infrequent limitations of function in a generally independent individual who is able to function with minimal supervision or assistance.

NOTE:

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

Four exceptions are noted:

- Criterion (a) and criterion (k)-7 are the same as they both involve medication administration. Only one may be used. Therefore, if an individual meets criterion (a), criterion (k)-7 may not be used as the second qualifying criterion.
- Criterion (g) and Criterion (k)-9 are the same as they both involve direction by a registered nurse. Only one may be used. Therefore, if an individual meets criterion (g), Criterion (k)-9 may not be used as the second qualifying criterion.
- Criterion (k) (3) cannot be used as a second criterion if used in conjunction with criterion (d) if the ONLY stoma (opening) is Gastrostomy or PEG tube.
- Criterion (k) (4) cannot be counted as a second criterion if used in conjunction with criterion (d) if used for colostomy, ileostomy or urostomy.

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NOTE:

The above criteria will be applied to all initials admissions to a nursing facility with the exception of Medicaid residents who have had no break in institutional care since discharge from a nursing facility and residents who are re-admitted in less than 30 days after discharge into the community. These residents need to meet only one criterion (a-k) in paragraph two, of the above.

Individuals admitted to a nursing facility as a private pay resident in spend down status with no break in institutional care for more than 30 days and becomes financially eligible for Medicaid, must meet only one of the criteria to transfer from private pay to a Medicaid admission.

Admission to a Nursing Facility from an Inpatient Psychiatric Hospital

A resident may temporarily transfer from an inpatient psychiatric hospital to a nursing facility for a two-week trial period. If the resident leaves the nursing facility before the two-week period has elapsed, the inpatient psychiatric hospital is responsible for reimbursing the nursing facility. If the resident has a successful trial period with the expectation of remaining in the facility long term, then the inpatient psychiatric facility will discharge the resident so that the nursing facility can admit him/her retrospectively to day one of the trial period. The nursing facility must ensure that the resident meets the nursing facility admission criteria. Additionally, the nursing facility must ensure that all required documents, Pre-Admission Screening and Resident Review and the Minimum Data Set are completed for these residents. The nursing facility will be reimbursed by Medicaid if financial eligibility and medical criteria are met, retrospectively to day one of the trial period.

Medical Director

The nursing facility shall retain a physician licensed under state law to practice medicine or osteopathy, to serve as medical director on a part-time or full-time basis as is appropriate for the needs of the residents and the facility.

- If the facility has an organized medical staff, the medical director shall be designated by the medical staff with approval of the governing body.
- A medical director may be designated for a single facility or multiple facilities through arrangements with a group of physicians, a local medical society, or a hospital medical staff, or through another similar arrangement.

The medical director is responsible for the overall coordination of the medical care in the facility to ensure the adequacy and appropriateness of the medical services provided to residents.

The medical director is responsible for the development of written by laws, rules, and regulations that are approved by the governing body and include delineation of the responsibilities of attending physicians.

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The medical director coordinates medical care by meeting with attending physicians to ensure that they write orders promptly upon admission of a resident, and periodically evaluating the professional and supportive staff and services.

The medical director is also responsible for surveillance of the health status of the facility's employees, and reviews incidents and accidents that occur on the premises to identify hazards to health and safety. The medical director gives the administrator appropriate information to help ensure a safe and sanitary environment for residents and personnel.

The medical director is responsible for the execution of resident care policies.

Conditions Under Which Nursing Facility Is Classified as Mental Disease Facility

If the facility under examination meets one of the following criteria, Medicaid considers the facility to be maintained primarily for the care and treatment of individuals with mental disease:

- It is licensed as a mental institution.
- More than fifty percent (50%) of the residents receive care because of disability in functioning resulting from a mental disease.

Mental diseases are those listed under the heading of Mental Disease in the Diagnostic and *Statistical Manual of Mental Disorders, Current Edition, International Classification of Diseases*, adopted for use in the United States, (ICD-10) or its successor, except mental retardation.

Conditions Under Which Nursing Facility Is Not Classified as Mental Disease Facility

Nursing facilities located on grounds of state mental hospitals or in the community must meet specific conditions in order to qualify for federal matching funds for care provided to all individuals eligible under the state plan.

Medicaid is responsible for coordinating with the proper agencies concerning the mental disease classification of nursing facilities. Facilities are NOT considered institutions for mental disease if they meet any of the following criteria:

- The facility is established under state law as a separate institution organized to provide general medical care and provides such care.
- The facility is licensed separately under state law governing licensing of medical institutions other than mental institutions.
- The facility is operated under standards that meet those for nursing facilities established by the responsible State authority.
- The facility is dually certified under Title XVIII and XIX.
- The facility is not maintained primarily for the care and treatment of individuals with mental disease.
- The facility is operated under policies that are clearly distinct and different from those of the mental institutions, and the policies require admission of residents from the community who need the care it provides.

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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 the preceding policy conditions in order to provide care to eligible individuals under the state plan.

The facilities that do not meet the conditions listed above are classified as institutions for mental diseases for Medicaid payment purposes. In such facilities, unless the facility is JCAHO-accredited as an inpatient psychiatric facility, payments are limited to Medicaid residents who are 65 years of age and older. If the facility is JCAHO-accredited as an inpatient psychiatric facility, payments may be made on behalf of the individuals who are under age 21 or are 65 years of age and older.

Medicaid Per Diem Rate Computation

The Medicaid per diem rate is determined under reimbursement methodology contained in the *Alabama Medicaid Agency Administrative Code*, Chapter 22. The rates are based on the cost data contained in cost reports (normally covering the period July 1 through June 30).

Reimbursement and Payment Limitations

Reimbursement is made in accordance with the *Alabama Medicaid Agency Administrative Code,* Chapter 22*.*

Each nursing facility has a payment rate assigned by Medicaid. The resident's available monthly income minus an amount designated for personal maintenance (and in some cases, amounts for needy dependents and health insurance premiums) is first applied against this payment rate, and then Medicaid pays the balance.

- The nursing facility may bill the resident for services not included in the per diem rate (non-covered charges) as explained in this section.
- The monthly income is prorated if the resident is not in the facility for the entire month.
- Actual payment to the facility for services rendered is made by the fiscal agent for Medicaid in accordance with the fiscal agent billing manual.

Medicaid defines a ceiling for operating costs for nursing facilities. Refer to the *Alabama Medicaid Agency Administrative Code,* Chapter 22, or contact the Provider Audit Division at the Agency for more details.

Nursing Facility Records

Nursing facilities are required to keep the following minimum records:

- Midnight census by resident name at least one time per calendar month (more frequent census taking is recommended)
- Ledger of all admissions, discharges, and deaths
- Complete therapeutic leave records
- A monthly analysis sheet that summarizes all admissions and discharges, paid hold bed days, and therapeutic leave days

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Cost Reports

Each provider is required to file a complete uniform cost report for each fiscal year ending June 30. Medicaid must receive the complete uniform cost report on or before September 15. Should September 15 fall on a state holiday or weekend, the complete uniform cost report is due the next working day. Please prepare cost reports carefully and accurately to prevent later corrections or the need for additional information.

Review of Medicaid Residents

Medicaid or its designated agent will perform a review of Medicaid nursing facility/ICF/IID facility residents' records to determine appropriateness of admission.

Medicaid or its designee will conduct a retrospective review on a monthly basis of 10% sample of admissions, re-admissions and transfers to nursing facilities to determine the appropriateness of the admission and re-admission to the nursing facility. This review includes whether appropriate documentation is present and maintained and whether all state and federal medical necessity and eligibility requirements for the program are met.

A nursing facility provider that fails to provide the required documentation or additional information for audit reviews as requested by the Agency or its designee within ten working days from receipt of the faxed letters shall be charged a penalty of one hundred dollars per recipient record per day for each calendar day after the established due date unless an extension request has been received and granted. The penalty will not be a reimbursable Medicaid cost. The Agency may approve an extension for good cause. Requests for an extension should be submitted in writing by the nursing facility Administrator to the Clinical Services & Support Division, Medical & Quality Review Unit with supporting documentation.

Electronic Upload and Submission of Medical Records

When submitting records the LTC Gainwell Cover Sheet from the web portal must accompany the medical record. LTC records for approval may be uploaded two different ways:

- Medicaid Interactive Web Portal (preferred)

  https://www.medicaid.alabamaservices.org/alportal/Account/Secure%20Site/tabId/22/Default.aspx

- Fax information in for processing (bar coded cover sheet required)

Documents must be in a Portable Document Format (PDF) for upload through the Medicaid web portal. If you do not currently have the ability to create PDF versions of medical records, you may perform an internet search and find free downloadable utilities that can be installed to create a PDF. For your convenience, a list of three PDF creation utilities that can be installed to create PDF documents at no charge.

- PrimoPDF – http://www.primopdf.com/
- Solid PDF – http://www.freepdfcreator.org/
- PDF24 – http://pdf24-pdf-creator.en.softonic.com/

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Once a PDF utility has been successfully downloaded and the PDF document created, providers should follow these steps to upload documentation for review:

1. Log on to Medical Interactive Web portal:

   https://www.medicaid.alabamaservices.org/alportal/Account/Secure%20Site/tabId/22/Default.aspx

2. Select Trade Files/Forms.

Forms Name field – select LTC Records from the drop down list and click on "Search".

3. Complete all fields (record ID field will auto populate). Required
4. Click on 'Browse' and select the required medical records documentation from your network drive or PC and select 'Submit'.
5. A message will be generated that states 'your form was submitted successfully' at the top of the page.
6. A barcode coversheet is generated and will be displayed.
7. Select the 'Print Friendly View' button to print the barcode coversheet or to save as a PDF. A copy of this barcode coversheet should be saved in the event additional documentation is required.

If a PDF document of the medical records cannot be created, information may also be faxed for review. A fax cover sheet will be required with each submission; providers should follow the instructions below to fax documentation:

1. Follow steps 1-7 documented above.
2. Fax the required medical records documentation with the barcode coversheet on top of the documentation to 334-215-7416.Include the bar coded cover sheet with each submission for the same recipient.
3. Do not fax double sided pages.
4. Do not fax multiple sets of records at the same time, each fax should be sent separately.

NOTE:

The bar code cover sheet is required for each fax submission for the same recipient. A fax submission cannot be processed without the bar coded cover sheet. DO NOT place anything on the bar code on the cover sheet or alter it any manner.

26.3 Establishment of Medical Need

The Medicaid Agency has delegated authority for the initial and subsequent level of care determination to long term care providers. Medicaid maintains ultimate authority and oversight of this process.

The process to establish medical need includes medical and financial eligibility determination.

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- The determination of level of care will be made by an RN of the nursing facility staff.
- Upon determination of financial eligibility the provider will submit required data electronically to Medicaid's fiscal agent to document dates of service to be added to the Level of Care file.

All Medicaid certified nursing facilities are required to accurately complete and maintain the following documents in their files for Medicaid retrospective reviews.

- New Admissions

  XIX LTC-9 Form 161. If criterion unstable medical condition is one of the established medical needs the provider must maintain supporting documentation of the unstable condition requiring active treatment in the 60 days preceding admission.

  A fully completed Minimum Data Set. However, the entire MDS does not have to be submitted for a retrospective review. Only the sections of the MDS which the facility deems necessary to establish medical need should be sent for a retrospective review.

  PASRR screening information, including the Level I Screening and Level I Determination and Level II Screening and Level II Determination if applicable.

  XIX-LTC-9 Form 161

  Updated PASRR screening information as required.

All Medicaid certified nursing facilities for individuals with a diagnosis of MI are required to maintain the following documents in their files. These documents support the medical need for admission or continued stay.

- New Admissions

  Medicaid Patient Status Notification (Form 199).

  Form XIX LTC-9 Form 161

  PASRR screening information, including the Level I Screening and Level I Determination and Level II Screening and Level II Determination if applicable.

All Medicaid certified ICF/IID facilities are required to complete and maintain the following documents in their files for Medicaid retrospective reviews. These documents support the ICF/IID level of care needs.

- New Admissions

  A fully completed Medicaid Patient Status Notification (Form 199).

  A fully completed ICF/IID Admission and Evaluation Data (Form XIX-LTC-18-22).

  The resident's physical history.

  The resident's psychological history.

  The resident's interim rehabilitation plan.

  A social evaluation of the resident.

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- Readmissions

  Medicaid Patient Status Notification (Form 199).

  ICF/IID Admission and Evaluation Form.

A total evaluation of the resident must be made before admission to the nursing facility or prior to authorization of payment.

An interdisciplinary team of health professionals, which must include the resident's attending physician, must make a comprehensive medical, social, and psychological evaluation of the resident's need for care. The evaluation must include each of the following medical findings: (a) diagnosis; (b) summary of present medical, social, and developmental findings; (c) medical and social family history; (d) mental and physical functional capacity; (e) prognosis; (f) kinds of services needed; (g) evaluation of the resources available in the home, family, and community; and (h) the physician's recommendation concerning admission to the nursing facility or continued care in the facility for residents who apply for Medicaid while in the facility and a plan of rehabilitation where applicable. The assessment document will be submitted with the LTC-9 on new admissions.

- Authorization of eligibility by Medicaid physician

For all applications for which a medical eligibility cannot be determined, the application should be submitted to the Clinical Services & Support Division, Medical & Quality Review Unit. The nurse reviewer will review and assess the documentation submitted and make a determination based on the total condition of the applicant. If the nurse reviewer cannot make the medical determination then the Alabama Medicaid Agency physician will approve or deny medical eligibility.

Application Denials

On each denied admission application, Medicaid advises the resident and/or personal representative, the attending physician, and the facility of the resident's opportunity to request a reconsideration of the decision and that they may present further information to establish medical eligibility.

If the reconsideration results in an adverse decision, the resident and/or personal representatives are advised of the resident's right to a fair hearing. If the reconsideration results in a favorable decision, normal admitting procedures are followed.

Signature Requirement

For information regarding electronic signature refer to Chapter 1-General Section of the Administrative Code Rule No. 560-X-.18.

26.4 Coverage for Ventilator-Dependent and Qualified Tracheostomy Care Residents

Ventilator-dependents and qualified tracheostomy residents recipients can choose any Medicaid nursing facility that has been approved to provide services to ventilator-dependent recipients.

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Information regarding the required medical eligibility and documentation for the nursing facility and the resident is included in Alabama Medicaid Administrative Code Chapter 63. Refer to the **Electronic Upload and Submission of Medical Records** section of this chapter for more information.

26.5 Cost Sharing (Copayment)

Copayment does not apply to services provided by nursing facility providers.

26.6 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers are encouraged to bill Medicaid claims electronically.

Nursing facility providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

NOTE:

When filing a claim on paper, a UB-04 claim form is required. Medicare-related claims must be filed using the Institutional Medicaid/Medicare-related Claim Form.

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

26.6.1 Time Limit for Filing Claims

Medicaid requires all claims for nursing facilities to be filed within one year of the date of service. Refer to Section 5.1.5, Filing Limits and Approved Exceptions, for more information regarding timely filing limits and exceptions.

26.6.2 Diagnosis Codes

The International Classification of Diseases - Current 10th Edition - Clinical Modification (ICD-10-CM) manual or its successor, lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, AMA Plaza 330 North Wabash Ave, Suite 39300 Chicago, IL 60611-5885, or 1-800-621-8335.

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NOTE:

ICD-9 codes should be used for claims submitted with dates of service prior to or equal to 09/30/2015.

ICD-10 codes should be used for claims submitted with dates of service on/after 10/01/2015.

NOTE:

ICD-9 or ICD-10 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

26.6.3 Covered Revenue Codes

Nursing facilities are limited to the following revenue codes:

Code	*Description*
101	All-inclusive room & board
183	Therapeutic leave
947	Nursing Home Ventilator

26.6.4 Place of Service Codes

Place of service codes do not apply when filing the UB-04 claim form.

26.6.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to claims with third party denials.

NOTE:

When an attachment is required, a hard copy UB-04 claim form must be submitted.

Refer to Section 5.8, Required Attachments, for more information on attachments.

26.7 For More Information

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

Resource	Where to Find It
UB-04 Claim Filing Instructions	Chapter 5
Institutional Medicaid/Medicare-related Claim Filing Instructions	Chapter 5
Medical Necessity/Medically Necessary Care	Chapter 7
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 and who are enrolled in the Alabama Medicaid program as a Medicaid provider or as an Ordering, Referring, or Prescribing Only provider (new PT 97)
- Dispensed and/or administered by a licensed pharmacist or licensed authorized physician in accordance with state and federal laws

The policy provisions for Pharmacy providers can be found in the *Alabama Medicaid Agency Administrative Code,* Chapter 16.

27.1 Enrollment

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

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

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

National Provider Identifier, Type, and Specialty

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

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NOTE:

The 10-digit NPI is required when filing a claim.

Pharmacy providers are assigned a provider type of 24 (Pharmacy). Valid specialties for Pharmacy providers include the following:

- Government Pharmacy 241
- Institutional Pharmacy 242
- Retail Pharmacy 240

Enrollment Policy for Pharmacy Providers

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

- Operate under a permit or license to dispense drugs as issued by the Alabama State Board of Pharmacy or appropriate authority in the State where the service is rendered. Enrolled locations must follow Federal and State rules for dispensing drugs off site.
- Agree to abide by the rules and regulations of third party billing procedures. Refer to Section 3.3.6, Third Party Liability, for more information.

  Maintain records, including prescriptions, to fully disclose the extent of services rendered. Pharmacies should maintain records, such as purchase invoices and recipient signature logs, within the state of Alabama. At a minimum, prescription files, recipient signature logs, and invoices must be available for examination.
- Agree that Medicaid or its designated representative may conduct audits of required records as necessary. Invoice records must be maintained and readily available for inspection.

Out-of-State Pharmacies

Under State and Federal regulations, a pharmacy must sign an agreement with Alabama Medicaid Agency. However, when a recipient is in another state and requires service, the following procedure has been adopted.

Pharmacies Bordering Alabama

- Pharmacies bordering Alabama may participate in the Alabama Medicaid Program by completing an application for out-of-state pharmacies, and upon certification of the State Board of Pharmacy in that state that the pharmacy is registered and has been issued a permit.
- The pharmacy must then sign a Pharmacy Vendor Agreement with Alabama Medicaid Agency and agree to abide by the State pharmacy provider tax law.
- Pharmacies bordering Alabama are defined as those pharmacies located not more than 30 miles from the border of Alabama.

Pharmacies Not Bordering Alabama

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- Drugs dispensed must be in concurrence with the limitations in place for in-state providers.
- Reimbursement will be made only for hemophilia factor products and specialty drugs which are not readily available in-state, and drugs dispensed to Medicaid recipients who may be traveling outside the state of Alabama.

- Providers of specialty drugs shall list the names of the drugs for which they intend to request reimbursement as well as the GCN or NDC numbers for each drug in the letter requesting enrollment with the Alabama Medicaid Agency.
- Pharmacies not bordering Alabama will be enrolled by the Medicaid fiscal agent on a temporary basis.
- Pharmacies not bordering Alabama are defined as those pharmacies located more than 30 miles from the border of Alabama.

Change of Ownership (CHOW) and Closures

Medicaid will mirror Medicare's Change of Ownership (CHOW) policy. Refer to Chapter 19, Hospital for additional information on Change of Ownership.

Part B Claims and DME Through a Pharmacy

Medicare covers certain prescription drugs under Part B with J codes (HCPC Codes) instead of NDC codes. Medicaid will allow these claims to be billed secondary to Medicare effective January 1, 2006. Examples of these drugs include hemophilia clotting factors, some immunosuppressive drugs for transplant patients (if the transplant was paid for by Medicare), some oral cancer drugs, erythropoietin analogs if the patient has End Stage Renal Disease, some injectable osteoporosis drugs, and some antigens if they are administered under doctor supervision. For more information on this issue, please visit the CMS website. A pharmacy must enroll as a DME provider to bill these services.

If the Alabama Medicaid pharmacy provider does not already have a provider number (ie enrolled as a DME provider) for filing Part B crossover claims, then the pharmacy provider will need to complete a separate provider enrollment application under a DME NPI in order to be allowed to bill for these services secondary to Medicare. Medicaid allows payment up to our allowed amount. Providers will be issued an additional pharmacy provider number, which will be used for filing secondary claims only. Once a provider number is received, Part B claims should crossover automatically to Medicaid from Medicare. However, if the Part B crossover claim did not crossover automatically, then the Part B crossover claim should be filed on a Medicaid/Medicare related claim form, or electronically through Provider Electronic Solutions software. Claim forms and software can be ordered by calling Provider Assistance at 1-800-688-7989.

In addition, a pharmacy may bill DME items (such as diabetic supplies, infusion supplies, etc.) through a 'medical' claim using HCPC Codes instead of NDC codes. A pharmacy must enroll as a DME provider to bill these services. Please see Chapter 14 of this manual for more

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information on DME enrollment. The Enrollment application can be found on the Medicaid website.

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. Refer to Chapter 7, Understanding Your Rights and Responsibilities as a Provider for general criteria on Medical Necessity/ Medically Necessary Care.

Medicaid pays for approved drug items when they are properly prescribed for eligible Medicaid recipients and dispensed in accordance with the *Alabama Medicaid Agency Administrative Code,* Chapter 16.

The number of outpatient pharmacy prescriptions for all recipients except as specified below is limited to four brand name drugs/ five total drugs per month per recipient. In no case can total prescriptions exceed ten per month per recipient. Prescriptions for Medicaid eligible recipients under age 21 in the Child Health Services/Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program and prescriptions for Medicaid eligible nursing facility residents are excluded from these limitations.

Anti-psychotic, anti-retroviral and anti-epileptic agents may be paid up to ten prescriptions per month but in no case can total prescriptions exceed ten per month per recipient.

Coverage of up to ten brand name prescriptions per month may be allowed through overrides for drugs classified by American Hospital Formulary Services (AHFS) or First Data Bank (FDB) Therapeutic Class as Antineoplastic Agents, Antiarrhythmic Agents, Cardiotonic Agents, Miscellaneous Vasodilating Agents, Miscellaneous Cardiac Agents, Nitrates and Nitrites, Alpha Adrenergic Blocking Agents, -Beta Adrenergic Blocking Agents, Dihydropyridines, Miscellaneous Calcium Channel Blocking Agents, Diuretics, Angiotensin-Converting Enzyme Inhibitors, Angiotensin II Receptor Antagonists, Mineralocorticoid (Aldosterone) Receptor Antagonists, Central Alpha Agonists, Direct Vasodilators, Peripheral Adrenergic Inhibitors, Miscellaneous Hypotensive Agents, Hemostatics, Calcium Replacements, Electrolyte Depleters, Immunosuppresives, Alpha Glucosidase Inhibitors, Amylinomimetics, Biguanides, Dipeptidyl Peptidase-4 Inhibitors, Incretin Mimetics, Insulins, Meglitinides, Sulfonylureas, Thiazolidinediones and Miscellaneous Diabetic Agents. Overrides will be granted only in cases in which the prescribing physician documents medical necessity for the recipient to be switched from a product in one of the above named classes to a brand name product within the same therapeutic class in the same calendar month. The first product must have been covered by Medicaid.

Medicaid will not compensate pharmacy providers for:

- DESI and IRS drugs which may be restricted in accordance with Section 1927(d)(2) of the Social Security Act
- Agents when used for anorexia, weight loss, or weight gain except for those specified by the Alabama Medicaid Agency

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- Agents when used to promote fertility except for those specified by the Alabama Medicaid Agency
- Agents when used for cosmetic purposes or hair growth except for those specified by the Alabama Medicaid Agency
- Agents when used for the symptomatic relief of cough and cold except for those specified by the Alabama Medicaid Agency
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations and others as specified by the Alabama Medicaid Agency
- Nonprescription drugs except for those specified by the Alabama Medicaid Agency
- Covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee
- Agents when used for the treatment of sexual or erectile dysfunction unless prior approved through medical necessity.

Refer to the *Alabama Medicaid Agency Administrative Code,* Chapter 16 for drugs not covered by Alabama Medicaid.

Unit Dosing in Nursing Facilities

Covered drug items may be dispensed to recipients, using an approved unit dose system for solid oral forms of the prescribed drug. Only one claim per drug per recipient may be submitted each month by any pharmacy using an approved unit dose system. Only the amount of the prescribed drug actually consumed by the patient may be billed.

Each dose of a drug dispensed using an approved unit dose system must be individually packaged in a sealed, tamper proof container and carry full disclosure labeling, including, but not limited to, product name and strength, manufacturer's or distributor's name, lot number and expiration date.

Prescriptions for controlled drugs must be filled or dispensed from a signed original or direct copy of the physician's prescription order.

27.2.1 Prescription Requirements

Medicaid reimburses for prescriptions documented and dated appropriately for legend and over-the-counter drugs covered by Medicaid.

Schedule II drug prescriptions require the manual signature of the prescribing physician before dispensing. Stamped or typewritten signatures are not acceptable. In accordance with the Code of Federal Regulations, § 1306.05, all prescriptions for schedule II substances shall be dated and signed by the prescribing physician the day when issued and shall bear the full name and address of the patient, the drug name, strength, dosage form, quantity prescribed, directions for use and the name and address and registration number of the practitioner.

Prescriptions dispensed by telephone for drugs other than Schedule II drugs are acceptable without subsequent signature of the practitioner.

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Pharmacy providers should document any changes to the original prescription, such as physician approved changes in dosage, on the original prescription.

The pharmacy may refuse to accept Medicaid reimbursement for a Medicaid-covered item and bill the recipient as a regular paying patron if the provider informs the recipient prior to dispensing the prescription. The recipient has the right to have the prescription filled by any other authorized Medicaid pharmacy.

Effective April 1, 2008, all prescriptions for outpatient drugs for Medicaid recipients which are executed in written (and non-electronic) form must be executed on tamper-resistant prescription pads. The term "written prescription" does not include e-prescriptions transmitted to the pharmacy, prescriptions faxed to the pharmacy, or prescriptions communicated to the pharmacy by telephone by a prescriber. This requirement does not apply to refills of written prescriptions which were executed before April 1, 2008. It also does not apply to drugs provided in nursing facilities, intermediate care facilities for the mentally retarded, and other institutional and clinical settings to the extent the drugs are reimbursed as part of a per diem amount or where the order for a drug is written into the medical record and the order is given directly to the pharmacy by the facility medical staff.

- If a written prescription is received which is not on a tamper-resistant prescription blank, the pharmacy must contact the prescribing provider and either have the prescription re-submitted in compliant written form or convert the prescription, where otherwise allowable, into verbal, faxed or electronic form.

- In an emergency situation where the pharmacy is unable to contact the prescribing provider, the pharmacy may choose to fill the prescription from the non-compliant form and subsequently obtain a prescription in compliant form. If a compliant prescription cannot be obtained within 72 hours, the pharmacy must withdraw the claim.

- To be considered tamper-resistant on or after April 1, 2008, a prescription pad must contain at least one of the following three characteristics:

    1. one or more industry-recognized features designed to prevent unauthorized copying of a completed or blank prescription form; or
    2. one or more industry-recognized features designed to prevent the erasure or modification of information written on the prescription by the prescriber; or
    3. one or more industry-recognized features designed to prevent the use of counterfeit prescription forms.

- To be considered tamper-resistant on or after October 1, 2008, a prescription pad must contain all of the foregoing three characteristics.

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Effective May 1, 2008, an override will be required for a brand name drug with an exact generic equivalent submitted with a Dispense as Written code of 1. In this case, the provider must provide documentation of the medical necessity for the brand name, rather than the available generic equivalent and receive an override. This override applies to those instances where the prescriber has written a prescription for a brand name drug when a pharmaceutically and therapeutically equivalent drug product is available generically. Exclusions to this process include carbamazepine, levothyroxine, phenytoin, and warfarin. Overrides may be completed and faxed or mailed to the Pharmacy Administrative Services contractor, currently Keystone Peer Review Organization, Inc. (Kepro).

In accordance with Section 5042 of the SUPPORT Act, effective October 1, 2021, prescribers of Medicaid eligible recipients are required to check the Alabama PDMP (Prescription Drug Monitoring Program) prior to prescribing a Schedule II controlled substance. If the prescriber does not check the PDMP, the prescriber is required to document the reason in the medical record. Exclusions to this requirement include prescriptions written for hospice patients, patients with an active cancer diagnosis, residents of a long-term care nursing facility, and children under the age of 18 (Schedule II prescriptions for ADHD only).

27.2.2 Appropriate Utilization of Dispense As Written (DAW) Codes

Dispense As Written (DAW) product selection codes are an integral part of accurate billing to the Alabama Medicaid Agency and provide the agency with the reason why a specific brand or generic is dispensed based on the prescriber's instructions. Failure to accurately use DAW codes results in misinformation to the Pharmacy program and its decision making process. Misinformation on claims may also result in retrospective pharmacy review and/or recoupment. Inaccurate usage of DAW codes is among one of the discrepancies found during an audit and is one of the Primary Pharmacy Audit Components listed in the Provider Billing Manual Section 27.2.5. The following codes are the various DAW codes available to the Alabama Medicaid Pharmacy program with explanations that have been taken from the National Council on Prescription Drug Programs (NCPDP) version 5.1 data dictionary for field 408-D8 Product Selection Codes. Providers should utilize the correct codes based upon the information submitted on the prescription and the prescriber's signature:

- **0=No Product Selection Indicated-**This is the field default value that is appropriately used for prescriptions where product selection is not an issue. Examples include prescriptions written for single source brand products and prescriptions written using the generic name and a generic product is dispensed.

- **1=Substitution Not Allowed by Prescriber**-This value is used when the prescriber indicates, in a manner specified by prevailing law, that the product is to be Dispensed As Written.

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- **2=Substitution Allowed-Patient Requested Product Dispensed**-This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted and the patient requests the brand product. This situation can occur when the prescriber writes the prescription using either the brand or generic name and the product is available from multiple sources. *(Not permitted by Alabama Medicaid)*

- **3=Substitution Allowed-Pharmacist Selected Product Dispensed**-This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted and the pharmacist determines that the brand product should be dispensed. This can occur when the prescriber writes the prescription using either the brand or generic name and the product is available from multiple sources.

- **4=Substitution Allowed-Generic Drug Not in Stock**-This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted and the brand product is dispensed since a currently marketed generic is not stocked in the pharmacy. This situation exists due to the buying habits of the pharmacist, not because of the unavailability of the generic product in the marketplace.

- **5=Substitution Allowed-Brand Drug Dispensed as a Generic**-This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted and the pharmacist is utilizing the brand product as the generic entity.

- **6=Override** *(Not permitted by Alabama Medicaid)*

- **7=Substitution Not Allowed-Brand Drug Mandated by Law**-This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted but prevailing law or regulation prohibits the substitution of a brand product even though generic versions of the product may be available in the marketplace.

- **8=Substitution Allowed-Generic Drug Not Available in Marketplace**-This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted and the brand product is dispensed since the generic is not currently manufactured, distributed, or is temporarily unavailable. *(In the event of an audit, provider shall make available documentation to validate product unavailability).*

- **9=Substitution Allowed- Plan Requests Brand Dispensed –** This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted,

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but the plan's formulary requests the brand product to be dispensed.

To indicate instructions to the dispensing pharmacy, a physician simply signs the prescription in a manner specified by prevailing law to indicate to a providing pharmacy whether or not generic substitution is allowed. Effective May 1, 2008 an override form and Medwatch 3500 form is required in order to medically justify a provider's reason for requesting a branded product when an exact generic equivalent is available. DAW overrides and the Medwatch 3500 form should be submitted to the Pharmacy Prior Authorization contractor.

27.2.3 Quantity Limitations

Claims must be submitted in the units specified on the prescription by the prescribing physician up to a 34 day supply. Medications supplied in a dosage form that would prevent the dispensing of an exact 30-34 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 prescription into small units and submit them as separate claims in order to obtain additional dispensing fees.

A pharmacist should not change quantities (units) of drugs prescribed by a physician except by authorization of the physician. The pharmacist must contact the prescribing physician for authorization to reduce the quantity of any Medicaid prescription and note physician authorization on the prescription form.

If the prescription to be paid by Medicaid exceeds the drug's maximum unit limit allowed per month, the prescriber or pharmacist must request an override for the prescribed quantity. If the override is denied, then the excess quantity above the maximum unit limit is non-covered and the recipient can be charged as a cash recipient for that amount in excess of the maximum unit limit. In other words, for a prescription to be "split billed" (the maximum unit allowed paid by Medicaid and the remainder paid by the patient), a maximum unit override must be requested by the provider and denied. A prescriber should not write separate prescriptions, one to be paid by Medicaid and one to be paid as cash, to circumvent the override process.

NOTE:

A provider's failure or unwillingness to go through the process of obtaining an override does not constitute a non-covered service.

If the full quantity prescribed is not available at the time of dispensing, the pharmacist may dispense the quantity available. In this case the pharmacist must note on the prescription the number of units dispensed and retain the claim until the balance of medication is dispensed. Only one claim with one dispensing fee may be billed.

Long Term Maintenance Supply

Effective October 1, 2013, the Alabama Medicaid Agency reimburses for a three month supply of Agency designated maintenance medications

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dispensed to recipients. A maintenance medication is an ordered/prescribed medication generally used to treat chronic conditions or illnesses and taken regularly and continuously. The following criteria apply to the three month supply:

- The medications will be designated by the Agency
- The three month supply medications listing(s) will be available to the public on the State's website: www.medicaid.alabama.gov
- The recipient must demonstrate 60 consecutive days of stable therapy (same strength and dose) within a 90 day timeframe, according to Medicaid claims data, prior to the State reimbursing the provider for dispensing a three month supply. This means the patient must have shown to be compliant/stable on the medication according to Medicaid claims data.
- An opt out program for recipients who may not be candidates for maintenance supplies will be available. The recipient's prescribing physician will need to provide documentation regarding the opt out reasons for each applicable recipient.
- Effective May 1, 2014, drugs on Medicaid's three month maintenance medication list will be excluded from the monthly five prescription limit of adults. This exclusion is regardless of whether the claim is for a three month supply or one month supply (during the first 60 days to establish stable therapy).
- The three month supply medications require that 90% of the medication be exhausted before they can be refilled.

Deleted: ~~A three month…it is filled.~~
Added: Effective May 1…establish stable therapy).

NOTE:
If the drug to be dispensed is included in the Agency's three month supply program, a pharmacist may shift a patient to a three month supply of prescribed drug using the existing prescription, pending enough units are remaining on the prescription authorized by the physician. Pharmacists may not add total units to a prescription unless authorized by the prescriber and documented in the patient file.

Short Acting Opioid Naïve Limits

Effective November 1, 2018, the Alabama Medicaid Agency began implementing limits on short-acting opiates for opioid naïve recipients. The Agency defines "opioid naïve" as a recipient with no opioid claim in the past 180 days.

Edit Details:

- A 7-day supply limit for adults age 19 and older
- A 5-day supply limit for children age 18 and younger
- A maximum of 50 morphine milligram equivalents (MME) per day allowed on a claim for an opioid naïve recipient
- Any claim for a short acting opioid for an opioid naïve recipient exceeding the maximum days' supply limit or MME limit will be denied.

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- Claims prescribed by oncologists will bypass the edit.
- Long term care and hospice recipients are excluded.
- Refills of remaining quantities and/or new prescriptions filled within 180 days of the initial opioid naive claim **will require an override.**
- Refills of remaining quantities of prescriptions that are partially-filled will be allowed per State and federal law* but will require an override through Medicaid. See below for more details from the State Board of Pharmacy.
- For adults, the refill of the quantity remaining on the partial fill **will not count** towards the prescription limit if filled within 30 days of the original prescription. Monthly maximum unit quantities still apply.
- Overrides for quantities exceeding the maximum days' supply limit or MME limit may be submitted to Keystone Peer Review Organization, Inc. (Kepro). Please see the Pharmacy Override External Criteria Booklet for information about override requirements. Please refer to the following link for more information regarding overrides for opioid naïve patients: http://medicaid.alabama.gov/alert_detail.aspx?ID=12978
- A Recipient Information Sheet for prescribers and pharmacists to provide to recipients can be found at http://www.medicaid.alabama.gov/content/4.0_Programs/4.3_Pharmacy-DME.aspx

NOTE:

A recipient may not pay cash for the remaining amount over 7 days for the same prescription of a Medicaid-paid opioid claim (ie a single fill/dispense/claim may not be 'split billed' to both Medicaid and cash). If the prescription to be paid by Medicaid exceeds the drug's limit allowed, an override may be requested. Only if the override is denied, then the excess quantity above the maximum unit limit is deemed a non-covered service, and the recipient can be charged as a cash recipient for that amount *in excess* of the limit. A prescriber must not write separate prescriptions, one to be paid by Medicaid and one to be paid as cash, to circumvent the override process. FAILURE TO ABIDE BY MEDICAID POLICY MAY RESULT IN RECOUPMENTS AND/OR ADMINISTRATIVE SANCTIONS.

27.2.4 Prescription Refill

Prescriptions cannot exceed eleven refills for non-controlled prescriptions and five refills for Control III-V prescriptions. Medicaid will deny claims for prescription refills exceeding eleven for non-controlled prescriptions and five for Control III-V prescriptions. Prescriptions may be refilled only with the prescribing provider's authorization. Failure of the prescribing provider to designate refills on a prescription will be interpreted as no refills authorized. If a prescription is refilled, the date the prescription is refilled must appear on the prescription.

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Pharmacy providers should refill all prescriptions only in quantities corresponding to dosage schedule and refill instructions.

The use of automatic refills by pharmacies is not allowed by the Medicaid Agency. Prescriptions that have been filled but not picked up by the patient or patient's authorized representative should be credited back to pharmacy stock and Medicaid through claims reversal within sixty days.

Violations of these policies may result in unauthorized charges. The pharmacy may be held liable or Medicaid may cancel the pharmacy vendor agreement.

Early/Timely Refills

Medicaid allows timely refills, defined as utilization of 85% of opioid agonist and opiod partial agonist claims, 90% of drugs on the 3-month maintenance list, and 75% of all other medications. Timely refills are based on the days' supply on a pharmacy claim; day's supply is an integral part of a valid claim, and should represent the actual days' supply of a claim based on the prescriber's instructions and quantity of drug dispensed. Claims processed prior to the timely refill allowance will require an override.

Medicaid utilizes an accumulation edit to limit dispensing of early refills to no more than seven extra days' worth of medication per 120 rolling days. Claims that exceed or result in the accumulation of more than seven extra days' worth of medication in a 120 - day time period will deny.

NOTE:

Medicaid may recoup payments for early refills.

Keystone Peer Review Organization, Inc. (Kepro) 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 Kepro before payment will be made. **Contact Kepro at 1 (800) 748-0130**. Only Kepro can issue the necessary override.

NOTE:

HOLDING OF MEDICATIONS FOR LTC RESIDENTS

When a resident leaves a LTF facility and is expected to return, the facility shall hold all medications until the return of the resident. All continued or re-ordered medications will be placed in active medication cycles upon the return of the resident. If the resident does not return to the facility within 30 days, any medications held by the facility shall be placed with other medications for destruction or distribution as permitted by the State Board of Pharmacy regulations. If at the time of discharge it is known that the patient will not return, medications may be destroyed or donated as allowed by State law.

If the medications are not held in accordance with this policy, the facility will be responsible for all costs associated with replacement of the medication.

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27.2.5 Reimbursement for Covered Drugs and Services

This section describes reimbursement for multiple source drugs, over-the-counter medications and other drugs, dispensing fees, vaccine administration and pricing.

Medicaid pays for certain legend and non-legend drugs prescribed by practitioners legally licensed by the state of Alabama to prescribe the drugs authorized under the program and dispensed and/or administered by a licensed pharmacist or licensed authorized physician in accordance with state and federal laws as stated in Administrative Code Rule 560-X-16-.01.

A. Notwithstanding specific reimbursement described in this section, payment for covered outpatient drugs (both brand and generic) dispensed by a:

1. Retail community pharmacy
2. Specialty pharmacy
3. Long-term care or institutional pharmacy (when not included as an inpatient stay)
4. 340B eligible entities (including 340B contract pharmacies) not listed on the U.S. Department of Health and Human Services Health Resources & Service Administration (HRSA) 340B Drug Pricing Program Database
5. Indian Health Service, Tribal and Urban Indian pharmacy

Shall not exceed the lowest of:

a. Effective January 1, 2021, The Alabama Average Acquisition Cost (AAC) of the drug; when no AAC is available, the Wholesale Acquisition Cost (WAC)-4% for brand drugs and WAC + 0% for generic drugs, plus a professional dispensing fee of $10.64,

b. The Federal Upper Limit (FUL), plus a professional dispensing fee of $10.64, or

c. The provider's Usual and Customary (U&C) charge to the general public regardless of program fees.

B. Payment for blood clotting factor products will be the Average Sales Price (ASP) + 6% plus a professional dispensing fee of $10.64.

C. For eligible 340B entities listed on the U.S. Department of Health and Human Services Health Resources & Service Administration (HRSA) 340B Drug Pricing Program Database, payment shall not exceed the entity's actual acquisition cost for the drug, as charged by the manufacturer at a price consistent with the Veterans Health Care Act of 1992, plus a professional dispensing fee of $10.64.

D. For facilities purchasing drugs through the Federal Supply Schedule (FSS), payment shall not exceed the entity's actual acquisition cost for the drug, plus a professional dispensing fee of $10.64.

E. For facilities purchasing drugs at Nominal Price, payment shall not exceed the entity's actual acquisition cost for the drug, plus a professional dispensing fee of $10.64.

F. Physician Administered Drugs (PADs) are reimbursed at a rate of ASP+ 6%. For PADs that do not have a published ASP, the reimbursement is

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calculated based on published compendia pricing such as Wholesale Acquisition Cost (WAC). For PADs administered by 340 entities, payment shall not exceed the entity's actual acquisition cost for the drug.

G. Investigational drugs not approved by the FDA are not covered.

Prescription Compounding

Alabama Medicaid pays for prescription drugs through the billing of NDCs. Pharmacists may dispense compounded medications when prescribed and must bill for each ingredient with a valid NDC on a single claim. Bulk products (i.e. powders) used for compounded medications are non-covered for adults (aged 21 and older). Some exclusions may apply. Bulk products must be submitted as a compound claim. Bulk products submitted on a pharmacy claim will deny.

The finished compound must not be available as a legend or over-the-counter product in an equivalent dosage form/route of administration. Compound products are subject to review, must meet medical criteria and may require peer-reviewed medical literature before being covered.

The maximum payable amount for a compounding product is $200 per claim. Requests for overrides for compounded products that exceed $200 should be referred to Kepro at 1 (800) 748-0130.

Other Drugs

Reimbursement for covered drugs other than multiple source drugs will not exceed the lower of the Alabama Estimated Acquisition Cost (AEAC) for the drug plus a reasonable dispensing fee, OR the provider's Usual and Customary Charge to the general public for the drug. For blood clotting factor products, Medicare Part B Drug pricing plus a reasonable dispensing fee is utilized.

Dispensing Fees

A reasonable dispensing fee is set by the Agency. The fee is reviewed periodically for reasonableness and, when deemed appropriate by Medicaid, may be adjusted. The dispensing fee paid by the agency effective September 22, 2010 is $10.64.

Only one dispensing fee is allowed for a 34 day supply of the same drug per month unless the recipient qualifies for an “early refill”. To qualify for an “early refill”, the recipient must have used 75% of the original supply or there is a documented consultation with the prescribing physician authorizing the refill.

Over-the-Counter Medications (OTCs)

Medicaid pays for certain OTCs through the Medicaid pharmacy program. OTCs dispensed to an eligible Medicaid recipient may be submitted for payment by utilizing the appropriate NDC number.

Over-the-counter medications require a prescription from a physician or other practitioner legally licensed by the State of Alabama to prescribe the drugs authorized under the program. Telephone prescriptions are acceptable for OTCs.

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Long term care facilities may bill OTC insulins covered by the Medicaid pharmacy program by submitting for payment the NDC number utilized. All other OTCs should be billed by the nursing facility using the facility cost report.

Do not dispense more medication than indicated on the prescription unless authorized by the prescribing physician to do so.

Medicaid will reimburse for covered OTCs as stated under Multiple Source Drugs.

Non-Drug Items

Alabama Medicaid Agency reimburses for certain non-drug items, including but not limited to spacers, syringes, and tablet splitters, through the pharmacy program with a valid prescription and NDC number. Other supplies such as blood glucose testing strips and lancets may be billed through Durable Medical Equipment. Please refer to chapter 14.2 for complete information.

Vaccine Administration

Alabama Medicaid will reimburse Medicaid-enrolled pharmacy providers for the administration of all vaccines recommended by the Advisory Committee on Immunization Practices (ACIP) for ages 19 and older. A list of ACIP recommended vaccines can be located on the CDC website under the vaccine page.

Claims for a vaccine and the administration of the vaccine will be submitted on the same claim. Pharmacy providers should submit a claim for the vaccine (i.e. ingredient) with the appropriate NDC along with the administration fee in the Incentive Amount Submitted field (NCPDP Field 438-E3) on the same claim as the vaccine being administered.

A maximum reimbursement of $5 is allowed for each vaccine administration (current exception of $40 administration for COVID vaccine). Only one dispensing fee (for the ingredient) and copay (if applicable) will be applied to the claim. There is a maximum quantity for each vaccine administered of 1 injection per recipient within a timeframe in accordance with the CDC dosing regimen.

A prescription or standing order is required for each vaccine administered and should be retained on file for documentation purposes.

To facilitate coordination of care, Pharmacy providers are required to inform (via phone, fax, email, or mail) each recipient's PMP upon administration of any vaccines for which an administration claim is submitted. Documentation must be kept on file at the pharmacy of the notification to the PMP. If the PMP is unknown, the pharmacy may call the Alabama Medicaid Automated Voice Response System (AVRS) at 1-800-727-7848 to obtain the PMP information. Pharmacy providers may also notify the recipient's local Alabama Coordinated Health Network (ACHN) region to assist with finding a PMP; ACHN contact information can be located on the Agency website under Contacts/ACHN Contacts. A suggested Immunization Provider Notification Letter, which can be used to notify the PMP, can be found on the Agency website under Pharmacy/Vaccines.

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Alabama State Board of Pharmacy law and regulations should be followed regarding dispensing and administration of legend drugs/vaccines.

Total Parenteral Nutrition

Alabama Medicaid Agency may reimburse for total parenteral nutrition (TPN) through the pharmacy program if the order/prescription and recipient meets certain requirements. TPN solutions include those used for hyperalimentation, intradialytic parenteral nutrition (IDPN) and intraperitoneal nutrition (IPN). Please refer to chapters 35.2 and 28.2 for complete information.

TPN prescriptions/orders are written to provide a sufficient amount of medication necessary for the duration of the illness or an amount sufficient to cover the interval between physician's visits. TPN prescriptions/orders should be billed using a compound pharmacy claim based on a month's supply. It is Medicaid's policy that a prescription shall not be split into small units and submitted as separate claims in order to obtain additional dispensing fees.

340 B Pricing

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

Eligible entities are defined in 42 U.S.C. § 256b(a)(4).
When an eligible 340B entity other than a disproportionate share hospital, a children's hospital excluded from the Medicare prospective payment system, a free-standing cancer hospital exempt from the Medicare prospective payment system, sole community hospital, rural referral center, or critical access hospital submits a bill to the Medicaid Agency for a drug purchased by or on behalf of a Medicaid recipient, the amount billed shall not exceed the entity's actual acquisition cost for the drug, as charged by the manufacturer at a price consistent with the Veterans Health Care Act of 1992, plus the dispensing fee established by the Medicaid Agency.

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

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

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

27.2.6 Primary Pharmacy Audit Components

The following information serves as a general guide to the components of a Medicaid Pharmacy Audit. Although the list provided may not be all-inclusive, it covers most of the discrepancies found through on-site and desk review audits. Non-compliant prescriptions may result in recoupments. Questions regarding this information may be directed to Medicaid at (334) 353-4584.

- **Rx Hardcopy Requirements**
    - **Tamper Resistant Prescriptions –** Prescriptions for outpatient drugs for Medicaid recipients which are executed in written (and non-electronic) form must be executed on tamper-resistant prescription pads.
    - **Controlled Substance Prescriptions –** Medicaid follows all DEA and Alabama State Board of Pharmacy rules and regulations regarding controlled substance prescriptions. The prescribing physician must authorize all changes from the original prescription before dispensing, and any change must be documented on the prescription. Written controlled substance prescriptions require a manual signature by the practitioner.

- **Total Parenteral Nutrition (TPN) - TPN** prescriptions/orders include those used for hyperalimentation intradialytic parenteral nutrition (IDPN), and intraperitoneal nutrition (IPN). A certification statement of medical necessity must be written or stamped on the prescription/order, or accompany all TPN prescriptions/orders.
- **Claims Submission**
    - **Dispense As Written (DAW) Codes -** Use of DAW codes will be audited on a regular basis to ensure correct billing. For a detailed explanation of each DAW code, see Section 27.2.2 of the Provider Billing Manual.
    - **Emergency Prior Authorization (PA) -** The use of the emergency PA code is to be used only in cases of emergency. This code will be monitored, and recoupments will be initiated if the code is found to have been used inappropriately.

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- **Other Coverage Code (OCC) -** Pharmacy providers should file a patient's primary insurance prior to filing Medicaid. Once the primary payer has responded, the patient's claim can be submitted to Medicaid. The use of OCC's will be monitored regularly. For detailed information on OCC's, see Section 27.5.6 of the Provider Billing manual.

- **Timely Prescription Reversal -** If a patient or a patient's authorized representative has not picked up his/her prescription within sixty (60) days, the pharmacy is required to reverse the claim and credit Medicaid the amount originally billed.

- **High Cost Claims -** High cost prescription claims will be reviewed on a regular basis. The NDC number of the product actually dispensed should be billed, and the days supply should be clinically appropriate according to prescription instructions. All aspects of the claims will be reviewed for accuracy.

- **Inaccurate Billing -** Certain drug products are at increased risk for billing errors. Claims for these prescriptions will be reviewed on a regular basis. The NDC number of the product actually dispensed should be billed, and the days supply should be clinically appropriate according to prescription instructions. All aspects of the claim will be reviewed for accuracy.

- **Usual & Customary (U&C)** - For specified products, submitted charge will be compared to cash price to general public. Adjustments may be initiated.

- **Out of State Providers -** Claims submitted by out of state providers will be reviewed regularly to ensure the medication dispensed is in accordance with the provider's enrollment guidelines.

- **Compound Prescriptions** - Claims for compounded prescriptions will be audited to ensure they follow all guidelines set forth in Chapter 27.2.4 in the Provider Billing Manual.

- **Multiple Dispensing Fees -** Providers must have documentation to include call-in and hard copy prescriptions to support the multiple dispensing of the same product to the same patient within an appropriate period of time.

- **Recipient Signatures** - Recipient signatures are required for all pharmacy claims to validate the service was rendered to the recipient and to ensure the recipient was offered appropriate counseling. For pharmacy items that have been delivered, the signature of the recipient or his/her designee is required. Pharmacies should maintain recipient signature logs for examination.

  Continued violations of Medicaid claims processing policies may result in recoupment and referral to the Alabama Attorney General's Office for investigation of fraud. Please visit CMS' Medicaid Program Integrity (MPIE) website at www.cms.gov. The site provides educational resources

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for providers, beneficiaries, managed care plans (MCPs) and other stakeholders and promotes best practices and awareness of Medicaid fraud, waste and abuse.

27.2.7 Drug Utilization Review (DUR)

The objective of DUR is to improve the quality of pharmaceutical care by ensuring that prescriptions are appropriate, medically necessary, and unlikely to result in adverse medical outcomes.

This section contains information about the components of the DUR Program:

- General Information
- Prospective Drug Utilization Review (Pro DUR)
- Online Drug Utilization Review (Online DUR)
- National Council for Prescription Drug Programs (NCPDP) Standards
- Retrospective Drug Utilization Review (Retro DUR)

General Information

The DUR Program uses educational tools directed to physicians and pharmacists in order to reduce the frequency of patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care by addressing:

- Potential and actual drug reactions
- Therapeutic appropriateness
- Over-utilization
- Under-utilization
- Appropriate use of generic products
- Therapeutic duplication
- Drug/disease contraindications
- Drug interactions
- Incorrect drug dosage or duration
- Drug allergy interactions
- Clinical abuse/misuse

The DUR Program reviews, analyzes and interprets patterns of drug usage against standards consistent with the American Medical Association Drug Evaluations, United States Pharmacopoeia Drug Index, American Hospital Formulary Service Drug Index, and peer reviewed medical literature.

DUR will be conducted for drugs dispensed to residents of nursing facilities.

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NOTE:

Pharmacists should refer cases of possible fraud or abuse to the Medicaid Program Integrity Division. Information may be provided through the Medicaid Agency's Fraud hotline by calling 1(866) 452-4930. Calls may be made anonymously.

Prospective DUR

Prospective DUR (Pro-DUR) is required at the point of sale or distribution before each prescription is filled or delivered to a Medicaid recipient. It must include screening, patient counseling, and use of patient profiles.

Pro-DUR screening is the responsibility of each Medicaid participating pharmacy and is a requirement for participation in the program.

Online DUR

Medicaid provides an online system to assist the dispensing pharmacist. Incoming drug claims are compared to the patient's medical and pharmacy claims history files to detect potential therapeutic problems. DUR alert messages are returned to the pharmacist for significant problems discovered by this review.

Potential problems identified include:

- Therapeutic duplication – Examples of therapeutic duplication, involving overlapping periods of time where such therapy is not medically indicated, include:
  - Two or more doses of the same drug
  - At least two drugs from the same therapeutic class
  - At least two drugs from different therapeutic classes with similar pharmacological effects being used for the same indication
- Drug/Disease contraindications
- Drug interactions
- Incorrect dosage or duration of drug treatment
- Drug allergy interactions
- Clinical abuse or misuse
- Preferred drug status

Medicaid distributes criteria and standards to providers in Medicaid Provider Notices and Bulletins.

Pharmacists must respond to prospective DUR alerts to continue claims processing through Gainwell.

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.

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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.

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Response fields and codes are listed in the following table:

Response Field	*Response Codes*
Conflict Codes	HD – High Dose ER – Early Refill LR – Late Refill DD – Drug-Drug Interaction TD – Therapeutic Duplication PS – Product Selection
Intervention Codes	M0 – Prescriber consulted P0 – Patient consulted R0 – Pharmacist consulted other source
Outcome Codes	1A - Filled As Is, False Positive 1B - Filled Prescription As Is 1C - Filled, with Different Dose 1D - Filled, with Different Directions 1E - Filled, with Different Dose 1F - Filled, with Different Quantity 2A - Prescription Not Filled 2B - Not Filled, Directions Clarified

NOTE:

Intervention codes contain the number zero, not the letter O. Using the letter O will cause your claim to deny online.

Proprietary pharmacy software for prescription processing systems may display DUR alerts in different formats. Examples of standard content of DUR messages are presented below. These may differ from the message actually displayed on the pharmacist's computer screen.

Example DUR Alert Messages	
On April 2, 1998, the pharmacist attempts to dispense an aspirin-containing product to a patient currently receiving welfare in prescribed by the same physician and filled at another pharmacy:	
CONFLICT CODE:	DD - DRUG INTERACTION
SEVERITY:	1 = Major
OTHER PHARMACY INDICATOR:	3 = Other Pharmacy
PREVIOUS FILL DATE:	19980315 (March 15, 1998)
QUANTITY OF PREVIOUS FILL:	30
DATABASE INDICATOR:	1 = First DataBank
OTHER PRESCRIBER INDICATOR:	1 = Same Prescriber
MESSAGE:	Coumadin
On April 19, the pharmacist attempts to dispense a refill for which the previous prescription has greater than 25 percent of days supply remaining:	
CONFLICT CODE:	ER - OVERUTILIZATON
OTHER PHARMACY INDICATOR:	1 = Same Pharmacy
PREVIOUS FILL DATE:	19980301 (March 1, 1998)
QUANTITY OF PREVIOUS FILL:	90
OTHER PRESCRIBER INDICATOR:	1 = Same Prescriber
The pharmacist attempts to dispense a refill of levothyroxine on May 15, a date equal to greater than 125 percent of previous prescription's days supply:	
CONFLICT CODE:	LR - UNDERUTILIZATION
OTHER PHARMACY INDICATOR:	1 = Same Pharmacy
PREVIOUS FILL DATE:	19980401 (April 1, 1998)
QUANTITY OF PREVIOUS FILL:	30
OTHER PRESCRIBER INDICATOR:	1 = Same Prescriber

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Example DUR Alert Messages	
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 Gainwell 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 Keystone Peer Review Organization, Inc. (Kepro) at 1(800) 748-0130 for overrides and prior authorization of drugs requiring prior approval. Only Kepro can issue prior authorizations and overrides.

Kepro should respond within 24 hours of receipt of requests for prior authorization and overrides. In cases of emergency, Kepro will make provisions for the dispensing of at least a 72-hour supply of a covered outpatient prescription drug.

Federal Law also makes a provision for a 72-hour supply by using the following authorization number: 0000999527. This number is to be used only in cases of emergency. Utilization of this code will be strictly monitored and recoupments will be initiated when the code is found to have been used inappropriately.

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27.3.1 Hemophilia Management Standards of Care

In order to be paid for providing blood clotting factor to Alabama Medicaid recipients, the provider must agree to provide, at the minimum, the following clinically appropriate items and services to their patients with hemophilia and blood clotting factor-related diseases:

(1) Home or office delivery of blood clotting factor and supplies. All shipments/delivery of clotting factor, including overnight deliveries, must use appropriate cold chain management and packaging practices to ensure proper temperature, drug stability, integrity, and efficacy are maintained during shipment.

(2) Educational materials and programs.

(a) The provider shall develop a training library at each enrolled provider location with materials for patient use, to include but not limited to, audio, video, electronic, and written materials.

(b) The provider shall offer educational materials to patient or family/caregiver at minimum at initiation of participation with the provider, yearly during the in-home assessment, and upon the request of Medicaid, the prescribing physician, or patient or family/caregiver. Topics of education shall include, but not be limited to, specific patient and family/caregiver education aimed at preventing injury that would result in a bleed, self-administration and reconstitution of blood clotting products.

(3) Medically necessary ancillary supplies required to perform the actual IV administration of clotting factor. Supplies may be billed to Medicaid through the Durable Medical Equipment (DME) program. In addition, sharps containers and any other necessary biohazardous waste containers shall be provided, as well as pickup and disposal of waste containers according to national, state and local biohazardous waste ordinances.

(4) Emergency telephone support 24 hours a day, 7 days a week to ensure patients are directed appropriately for care in emergent situations.

(5) For the purposes of this Rule and the Alabama Medicaid Agency hemophilia management standards of care, “clinical staff trained in hemophilia and related blood clotting factor related diseases” is defined as follows:

(a) Pharmacists are required to obtain a minimum of 2 Continuing Education (CE) credit hours per year that are specific to hemophilia or related blood clotting factor-related diseases.

(b) Nurses and social workers are required to obtain a minimum of 4 Continuing Education (CEU) hours per year that are specific to hemophilia or related blood clotting factor-related diseases.

Continuing education must be specific to hemophilia or related blood clotting factor-related diseases and recognized by a state or national hemophilia or bleeding disorder education/support group (for example: Hemophilia Federation of America or the National Hemophilia Association).

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(6) Emergency delivery of blood clotting factor within 24 (with a target of less than 12) hours of the receipt of a prescription for a covered person's emergent situation, or notification of the patient with an existing valid prescription. Emphasis should be placed during patient education of the importance of keeping an adequate supply on hand and self-administration for emergent situations.

(7) A pharmacist, nurse, and/or a case representative assigned to each patient. A case representative shall maintain, at a minimum, monthly telephone contact with the patient or family/caregiver to include, but not limited to:

- Inquiry regarding patient's current state of well-being
- Assessment of patient/family compliance/adherence, and persistence with the medical treatment plan
- Incidence of adverse events
- Incidences of supply or equipment malfunctions
- Home inventory check of factor and supplies
- Confirmation of next delivery date

Case representatives may include administrative support staff but must coordinate with clinical staff (as described in (5) above) in the event a clinical issue should arise.

(8) Compliance programs.

(a) The provider must assess patient adherence on monthly telephone contact (see (7) above) and on all in-home visits by a pharmacist, nurse, or case manager.

(b) The provider must verify the amount of clotting factor the patient has on hand prior to each dispense. Blood clotting factor and related products are not to be sent to the patient on an auto-ship basis. The provider shall discourage "stockpiling" of product.

(c) The number of bleeds and infusions from the prior shipment shall be tracked to validate the need for additional product or non-compliance with the medical treatment plan.

(9) Notification of product recalls or withdrawals.

(a) Any stock of recalled medications/equipment/supplies shall be removed from stock and quarantined immediately.

(b) Any recalled items dispensed to patients shall be retrieved and quarantined; notification to patients must occur within 24 hours of the recall receipt.

(c) The prescribing physician shall be notified of a medication recall. A prescription for an alternative product shall be obtained, if necessary.

(10) Visiting clinical services.

(a) At minimum, an initial and subsequent yearly in-home assessment of the patient, family/caregiver, and environment shall be conducted by a nurse or pharmacist trained in blood clotting factor related diseases.

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(b) Additional in-home assessments of the patient, family/caregiver, and environment deemed necessary by the physician or patient situation shall be conducted.

(c) Visits may be provided directly by the provider or by arrangement with a qualified local home health care agency. All hemophilia-related clinical staff must be trained in hemophilia and bleeding disorder related diseases.

(11) A registered pharmacist trained in blood clotting factor related diseases to perform assay to prescription management. Variance in assay to prescription/target dose should not exceed +/- 10%. Providers shall strive to dispense as close to the prescribed target dose within the assay variance as possible without breaking a new vial (i.e. do not dispense 'extra' vials, even if the 'extra' vials fall within the +/-10% variance). Extra vials dispensed within the +/-10% assay variance may be subject to recoupment. Pharmacists/pharmacy staff shall not change a Medicaid recipient's therapy based on the cost of the medication without prior written approval from the prescriber and noted in the patient chart.

(12) Adverse drug reaction and drug interaction monitoring and reporting.

(a) Pharmacists shall counsel the patient or family/caregiver in accordance with the Omnibus Budget Reconciliation Act of 1990 (OBRA 90) to encourage appropriate medication use, promote realistic therapy expectations, help recipients manage or minimize expected adverse effects and encourage compliance.

(b) Pharmacists shall report any issues or concerns related to the patient's medications to the physician. For significant events, utilization of the FDA 3500 MedWatch voluntary reporting form is encouraged.

(13) Continuation of Care. The provider shall not present any bill to or collect any monies from a covered Medicaid recipient with whom the provider has agreed to the provision of services and supplies for the home treatment of bleeding episodes associated with hemophilia, except as follows:

(a) to collect the copayments/coinsurance amounts the covered person is required to pay under the terms defined by Medicaid, or

(b) if the service/product has been deemed "non-covered" and the recipient has been notified in advance as outlined in the Alabama Medicaid Agency Administrative Code and Provider Billing Manual.

Upon discontinuation of services by the provider, the provider shall, at a minimum, coordinate for another designated health care provider to provide services to covered persons, prior to withdrawal of any hemophilia-related services from the home of any covered person. The provider shall continue to provide services and supplies to a covered individual until the individual obtains an alternate source of services and supplies. Every effort shall be made by the provider (including notification to the Medicaid Director of Pharmacy) to find an alternative provider to

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ensure that the coordination of care/transition follows the minimum standards of care as set forth in this document.

(14) The Alabama Medicaid Agency (or its designated representative), to ensure clinically appropriate services are being given to hemophilia patients, shall monitor providers of blood clotting factor by prospective and retrospective audits, as well as administer a patient/family/caregiver satisfaction survey to include, but not limited to, measurement of:

(a) staff availability

(b) staff knowledge

(c) timeliness of deliveries

(d) accuracy of supplies and equipment

(e) overall satisfaction

If a provider does not meet one or more of the standards for care, as outlined in this Rule, the Alabama Medicaid Agency shall provide a written notice of that determination, with an explanation therefore, to the provider. The provider will not be reimbursed for blood clotting factor or hemophilia related services until the provider meets the standards as approved by the Agency.

27.4 Cost Sharing (Copayment)

Copayment amounts vary and are described in this section. **Copayments do not apply to services provided for pregnant women, long term care (nursing home) residents, emergencies, recipients under 18 years of age, or family planning**.

Copayments do not apply to Native American Indians that present an "active user letter" issued by Indian Health Services (IHS). The provider must enter a value of '4' in the prior authorization type code field indicating co-pay exemption for a Native American Indian with an active user letter.

A provider may not deny services to any eligible Medicaid recipient because of the recipient's inability to pay the cost sharing (copayment) amount imposed.

- If the physician has indicated on the prescription that the recipient is pregnant, enter "P" in the copay block.

NOTE:
Do not enter a dollar amount in the copay block.

The copayment schedule is based on the total charge amount (ingredient cost plus dispensing fee):

Pharmacy Charge	***Copay Amount***
$10.00 or less	$0.65
$10.01 to $25.00	$1.30
$25.01 to $50.00	$2.60
$50.01 or more	$3.90

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NOTE:

Copayment amount should be collected on the original prescription as well as any refills.

Providers may use various resources to verify recipient eligibility:

- Provider Electronic Solutions software
- Software developed by the provider's billing service, using specifications provided by Gainwell
- Automated Voice Response System (AVRS) at 1(800) 727-7848
- Contacting the Gainwell Provider Assistance Center at 1(800) 688-7989

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

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

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

27.5 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, provider should bill Medicaid claims electronically.

Pharmacy providers who bill Medicaid claims electronically receive the following benefits:

- Faster claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

Most pharmacy claims are submitted electronically for online adjudication. Claims filed electronically use Provider Electronic Solutions software from Gainwell 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 Gainwell for payment. Gainwell will furnish pharmacy claim forms upon request.

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Pharmacy claim forms can be purchased from Gainwell for $35.44 per 1,000 forms. Claim forms will be mailed after receipt of payment.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

27.5.1 Time Limit for Filing Claims

Medicaid requires all claims for Pharmacy providers to be filed within one year of the date of service. Refer to Section 5.1.4, Filing Limits, for more information regarding timely filing limits and exceptions.

27.5.2 Diagnosis Codes

Diagnosis Codes do not apply when filing the pharmacy claim form.

27.5.3 Procedure Codes and Modifiers

Procedure Codes and Modifiers do not apply to Pharmacy billing.

27.5.4 Place of Service Codes

Formerly named Patient Location Code, new code values have been assigned. A value of either 31, 32, or 54 in 307-C7 will indicate the patient is in a Long Term Care (LTC) facility and the claim will be processed accordingly.

27.5.5 Required Attachments

Attachments are not required for pharmacy claims.

27.5.6 Third Party Liability (TPL) Payments

As a general rule, pharmacy providers are required to file a patient's primary insurance prior to filing Medicaid. Once the primary payer has responded, the patient's claim can be submitted to Medicaid. Medicaid will pay the Medicaid rate less any payment and applicable contractual adjustment. Medicaid should not pay more than the than the sum of the health plan's patient co-pay, coinsurance and/or deductible.

The following NCPDP codes should be used when billing Medicaid as the secondary payer:

- Other coverage code "02" (NCPDP field 308-C8) will require a TPL amount (431-DV) greater than zero.
- Other coverage code***s*** "02" and "04" (NCPDP field 308-C8) will require a patient responsibility amount (352-NQ) greater than zero.
- Other coverage code "03 - Other coverage exists- claim not covered" (NCPDP field 308-C8) will not require either TPL amount or patient responsibility amount to be greater than zero.

An exception to the rule is when the patient has a point of sale (POS) drug plan, which requires the cost of the prescription to be paid up front by the patient. Then a claim can be submitted to the insurance plan for reimbursement directly to the patient. These POS drug plans require special handling when the patient is also a Medicaid recipient.

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Click the following link for special instructions for pharmacies when the recipient has both Medicaid and a point-of-sale drug plan: https://medicaid.alabama.gov/content/7.0_Providers/7.1_Third_Party/7.1.6_Coord_Benefits.aspx

27.5.7 Prescription Origin Code

The code indicating the means used to deliver a prescription to a pharmacy – this is a required field. Valid values are:

0 = Not Known
1 = Written
2 = Telephone
3 = Electronic
4 = Facsimile
5 = Pharmacy

27.6 For More Information

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

Resource	Where to Find It
XIX-DC-10-093 Claim Filing Instructions	Chapter 5
Medical Necessity/Medically Necessary Care	Chapter 7
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N

27.7 Alabama Medicaid Pharmacy Questions and Answers (Q&A)

The Medicaid Pharmacy Q&A has been developed to provide guidance and clarification on pharmacy issues. Questions may be submitted to:

Medicaid Program Management, Fax (334) 353-7014

Responses will be published in the quarterly Medicaid Pharmacy Newsletter.

Are original prescriptions and signatures required for all drugs?

Medicaid requires original, signed prescriptions for Schedule II drugs. Schedule III, IV, and V drugs may be called in, as allowed by state pharmacy regulations.

Can I make a therapeutic or strength substitution without calling the prescribing physician?

No. Alabama State law requires the pharmacist to have the approval of the prescribing physician before dispensing anything other than what has been indicated on the prescription. If the physician has indicated product selection is allowed, the pharmacist may dispense generic substitution without subsequent contact with the physician.

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What is the appropriate action when a physician writes a prescription that exceeds the Medicaid monthly dosing units?

When a prescription is denied for excessive quantity or monthly limit exceeded, claims will deny. In order to receive an override, providers (either the pharmacy or physician) should contact the HID help desk at 1(800) 748-0130 for consideration of an override.

Can I "split bill" a prescription if the prescribed quantity exceeds the maximum units allowed?

If a prescription to be paid by Medicaid exceeds the drug's maximum unit limit allowed per month, the prescriber or pharmacist must request an override for the prescribed quantity. If the override is denied, then the excess quantity above the maximum unit limit is non-covered and the recipient can be charged as a cash recipient for that amount in excess of the maximum unit limit. In other words, for a prescription to be "split billed" (the maximum unit allowed paid by Medicaid and the remainder paid by the patient), a maximum unit override must be requested by the provider and denied. Note: A provider's failure or unwillingness to go through the process of obtaining an override does not constitute a non-covered service.

How long is a prescription valid?

In accordance with state law, controlled substance prescriptions, for schedule III-V, may be refilled up to five times within six months from the original issue date. Non-controlled prescriptions are reimbursable by Medicaid for up to 12 months from the date of the original dispensing date.

Can I receive authorization for additional refills from the prescribing physician after the 12 months have expired?

No. A new prescription should be obtained after 12 months from the date of the original dispensing date. Medicaid will make payment for up to 5 refills on an original prescription for Control III-V prescriptions and 11 refills on non-controlled prescriptions.

Why is it important that I bill the exact NDC number dispensed if the product is a generic?

According to the State Board of Pharmacy, pharmacies dispensing controlled substances and submitting claims with different NDC numbers would have problems with the Drug Enforcement Agency (DEA). Additionally, Medicaid provider contracts require that claims be submitted accurately. Under federal law, manufacturers rebate Medicaid for use of their drugs. When an NDC is submitted on a claim that is not the actual NDC dispensed, Medicaid may incorrectly invoice the manufacturer for the rebate. Rebate dollars provide a significant source of money to offset pharmacy benefit costs. Therefore, NDC numbers reported on pharmacy claims should be the exact NDC number dispensed to the patient.

Can referrals be made to the Medicaid Agency when a provider believes a recipient is defrauding the program?

Yes. Any information regarding inappropriate and/or illegal drug-related activity by Medicaid recipients can be referred to the **Medicaid Fraud Hotline** at **1(866) 452-4930**. All complaints are researched. If evidence is

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found to support recipient abuse or fraud, recipients can be locked in to one physician and one pharmacy or removed from the Medicaid program.

Does Medicaid make payment for benefits when a patient is in a state or county correctional facility?

Medicaid benefits are not available for individuals who are inmates of public institutions as defined by CFR 435.1009. It is the responsibility of the correction facility to provide medical care. Incarcerated recipients still receiving Medicaid benefits may be referred to the **Medicaid Fraud Hotline** at **1(866) 452-4930**.

If a provider receives multiple dispensing fees for the same patient, same drug and strength within the same month, will the additional dispensing fees be recouped?

Medicaid auditors look specifically for providers who split 30-day prescriptions into shorter time periods and amounts. Intentionally splitting prescriptions to receive multiple dispensing fees is fraud and monies paid will be recouped. Multiple dispensing fees within the same month for the same patient and same drug are acceptable if the provider has documentation supporting the need for multiple dispensings. Example: A child needs a 10 mg tablet for school and a 20 mg tablet for home to take at night; the provider should have in his documentation prescriptions for both.

If a provider is audited and cannot produce documentation while Medicaid auditors are in the store, is there a period of time allowed to provide the documentation before recoupments are initiated?

If an auditor requests documentation that is not present in the provider's facility, the provider should indicate to the auditor where the documentation is and when it can be provided for review. If additional information is needed by the state as a result of discrepancies identified in an audit, the provider should submit the requested information within 30 days of the request. Failure to submit documentation within 30 days may result in recoupment.

Is it important to bill the correct days supply?

Yes, days supply is an instrumental portion of a legitimate claim. Retroactive audits may consider the day supply billed, along with quantity of medication billed, in regards to the original prescription. Day supply billed should be clinically appropriate according to the physician's instructions on the prescription.

Can a pharmacy provider advertise waived copays for their Medicaid patients?

No. Advertising the waiver of or routinely waiving Medicaid copayments is a prohibited remuneration under Section 22-1-11, Code of Alabama and 1128B of the Social Security Act (SSA). Please refer to the Provider Manual, Chapter 7 "Understanding your rights and responsibilities as a provider", Section 7.1.8 "Provider Certification" for more information on offering incentives and advertising discounts.

Can a pharmacy enroll in Alabama Medicaid and dispense drugs off site?

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No*. Per the Alabama Medicaid Agency provider enrollment agreement: *"1.3.3: All claims or encounters submitted by Provider must be for services actually rendered by Provider."* This means that the dispensing of drugs to an Alabama Medicaid Agency recipient must occur by the rendering provider, who is enrolled and billing per the pharmacy NPI.

In addition, per Alabama Medicaid Administrative Code: Rule No. 560-X-16-.02 Requirements for Participation *(1) A pharmacy must be operating 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. (2) A pharmacy applicant must submit and have approved a pharmacy agreement signed by owner, authorized representative, pharmacist, or dispensing physician. (3) Pharmacies and dispensing physicians must agree to abide by the rules and regulations of the program; must agree that payment for covered services will be accepted as payment in full.* Therefore, unless approved by the Alabama Board of Pharmacy, the permitted pharmacy is permitted by the Alabama Board of Pharmacy for that particular location, and the dispensing from that permitted location must match the billing/service location of the enrolled pharmacy's NPI.

*The only exception allowed by Alabama Board of Pharmacy is: Section 34-23-70 of the Alabama Practice of Pharmacy Act 205: Management; display of permit and license; poisons; prescription requirements; violations: *(e) No pharmacy shall authorize any person, firm, or business establishment to serve as a pick-up station or intermediary for the purpose of having prescriptions filled or delivered, whether for profit or gratuitously. Except with respect to controlled substances, any facility recognized as a federally qualified health center, as defined in 42 U.S.C. §1396d(l)(2)(B), operating health care practices and providing pharmacy services in the state is expressly exempt from this subsection. Each eligible federally qualified health center is authorized to fill certain prescriptions at one location and deliver medications to clinics for patient pick-up subject to the review of the board.*

Sources: https://www.albop.com/StatutesAndRules.aspx ; https://medicaid.alabama.gov/documents/9.0_Resources/9.2_Administrative_Code/9.2_Adm_Code_Chap_16_Pharmaceutical_Services_12-14-20.pdf

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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

The Alabama Medicaid Agency fiscal agent 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.

Gainwell also enrolls Physician Assistants (PA), Certified Registered Nurse Practitioners (CRNP), Certified Registered Nurse Anesthetists (CRNA), and Anesthesiology Assistants (AA) who are employed by a Medicaid enrolled physician. Physician-employed includes physicians practicing in an independent practice or in a group practice relationship.

Refer to Chapter 38, Anesthesiology, for more information on CRNA and AA services.

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

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

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National Provider Identifier, Type, and Specialty

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

NOTE:
The 10-digit NPI is required when filing a claim.

Physicians are assigned a provider type of 31 (Physician). Nurse Practitioners are assigned a provider type of 09. Physician Assistants are assigned a provider type of 10. For a list of valid specialties for Nurse Practitioners and Physician Assistants, please refer to Chapter 21.

Valid specialties for physicians and practitioners include but are not limited to the list below:

Added: Dental Anesthesiology 279…311-Anesthesiology

Specialty (Physician - 31)	*Code*
Allergist	310
Anesthesiologist	311
Applied Behavior Analysis	175
Cardiac surgery	312
Cardiovascular disease	313
Cochlear implant team	740—See Chap. 10, Audiology/Hearing Services
Colon and rectal surgery	750
Dermatology	314
Dental Anesthesiology	279 (with inclusion of Specialty 311-Anesthsiology)
EENT	760
Emergency medicine Practitioner	315
Endocrinology	770
EPSDT	560
Family practice	316
Gastroenterology	317
General practice	318
General surgery	319
Geriatrics	320
Hand surgery	321
Hematology	780
Infectious diseases	790
Internal medicine	800
Mammography	292
Mobile Provider	299
Neonatology	323
Nephrology	324
Neurological surgery	325
Neurology	326
Nuclear medicine	327
Nutrition	230
Obstetrics/Gynecology	328
Oncology	329
Ophthalmology	330

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Specialty (Physician - 31)	*Code*
Oral and maxillofacial surgery	272
Orthopedic	810
Orthopedic surgery	331
Otorhinolaryngology	332
Pathology	333
Pediatrics	345
Plastic, reconstructive, cosmetic surgery	337
Primary care provider (not a screening provider but can refer patients)	720
Proctologist	338
Psychiatrist	339
Pulmonary disease Specialist	340
Radiology	341
Rheumatology	830
Telemedicine	931
Thoracic surgeon	342
Urologist	343
Vascular surgery	313

Enrollment Policy for Physicians

Providers (in-state and out-of-state) who meet enrollment requirements are eligible to participate in the Alabama Medicaid Program. The PA or CRNP must send a copy of the prescriptive authority granted by the licensing board in order for the PA or CRNP to be added to the Provider License File for the purpose of reimbursing the pharmacist for the prescriptions written by the PA or CRNP. This copy must be sent to Gainwell Provider Enrollment, P.O. Box 241685, AL 36124-1685.

Gainwell 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.

Enrollment Policy for Primary Care Enhanced Physician Rates or BUMP Rate

In order for PCPs to qualify for BUMP rates, the following requirements must be met:

A. A provider must meet one of the following requirements listed below:

1. A provider is eligible1 who has a specialty or subspecialty designation in family medicine, general internal medicine, or pediatrics that is recognized by the American Board of Medical Specialties (ABMS), the American Board of Physician Specialties (ABPS), or the American Osteopathic Association (AOA), and practice in their specialty.

2. A NON-board certified provider who practices in the field of family medicine, general internal medicine, or pediatrics or a subspecialty under one of these specialties, is eligible1 if he/she can attest that 60 percent of their paid Medicaid procedures billed are for certain specified procedure codes for evaluation and management (E&M) services and certain Vaccines for Children (VFC) vaccine administration codes.

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B. The following providers do not meet criteria for BUMP rates:

1. Federally Qualified Health Center (FQHC)
2. Rural Health Clinic (RHC)
3. Health Department (ADPH)
4. Teaching Facility
5. OB/GYNs
6. Nursing Facility

C. Eligible providers may enroll by:

1. Visit www.medicaid.alabama.gov
2. Select Provider Enrollment from the drop-down menu under "Providers" and then "Forms for Provider Enrollment and Revalidation"
3. Complete the "Bump" Self-Attestation Form
4. Attach proof of board certification, if applicable
5. Mail original self-attestation form to the address specified

D. Providers will receive payment at the enhanced rates for dates of service beginning with the date the self-attestation is entered into the system by the fiscal agent.

[1]As defined by 42 C.F.R. Pts.438, 441, and 447, interpreted by Centers for Medicare and Medicaid (CMS) guidance and consistent with the Alabama State Plan.

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. Refer to Chapter 7, Section 7.1.1 - "Medical Necessity/Medically Necessary Care", for general criteria on Medical Necessity/ Medically Necessary Care.

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. Physicians are to bill the Alabama Medicaid Agency their usual and customary fee.

Office visits are limited to one per day, per recipient, per provider. For purposes of this limitation, a physician or physician of the same specialty and subspecialty from the same group practice are considered a single provider. Annual office visit benefit limits are 14 office visits per calendar year.

Medicaid will no longer require physicians enrolled in and providing services through a **residency** training program be assigned a pseudo Medicaid license number to be used on prescriptions written for Medicaid recipients. Effective for claims submitted on or after January 1, 2012, interns and non-licensed residents must use the NPI or license number of the teaching, admitting, or supervising physician.

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Written medication prescriptions should have a typed or printed name of the prescriber on the prescription and the handwriting must be legible. Pharmacists **must have the physician's license number** prior to billing for prescriptions. Pharmacies shall use the correct physician license number when submitting a pharmacy claim to Medicaid.

Supervising physicians may bill for services rendered to Medicaid recipients by residents enrolled in and providing services through (as part of) an approved residency training program. The following rules shall apply to physicians supervising residents as part of an approved residency training program:

a. The supervising physician shall sign and date the admission history and physical progress notes written by the resident.

b. The supervising physician shall review all treatment plans and medication orders written by the resident.

c. The supervising physician shall be available by phone or pager.

d. The supervising physician shall designate another physician to supervise the resident in his/her absence.

e. The supervising physician shall not delegate a task to the resident when regulations specify that the physician perform it personally or when such delegation is prohibited by state law or the facility's policy.

Payments from Medicaid funds can be made only to physicians who provide the services; therefore, no reimbursement can be made to patients who may personally pay for the service rendered.

The physician agrees when billing Medicaid for a service that the physician will accept as payment in full, the amount paid by Medicaid for that service, plus any cost-sharing amount to be paid by the recipient, and that no additional charge will be made. Conditional collections from patients, made before Medicaid pays, which are to be refunded after Medicaid pays, are not permissible. The physician may bill the patient, in addition to the cost-sharing fee, for services rendered when benefit limitations are exhausted for the year or when the service is a Medicaid non-covered benefit. However, the provider (or their staff) must advise each patient prior to services being rendered when Medicaid payment will not be accepted, and the patient will be responsible for the bill. If a provider routinely accepts a Medicaid assignment, he or she may not bill Medicaid or the recipient for a service he or she did not provide, i.e., missed or canceled appointment.

A hospital-based physician who is a physician employed by and paid by a hospital may not bill Medicaid for services performed therein and for which the hospital is reimbursed. A hospital-based physician shall bill the Medicaid Program on a CMS-1500, Health Insurance Claim Form or assign their billing rights to the hospital, which shall bill the Medicaid Program on a CMS-1500 form. A hospital-based physician who is not a physician employed by and paid by a hospital shall bill Medicaid using a CMS-1500 claim form.

A physician enrolled in a residency training program and whose practice is limited to the institution in which that resident is placed shall not bill Medicaid for services performed therein for which the institution is reimbursed through the hospitals' cost reports. For tracking purposes, these physicians will be assigned pseudo Medicaid license numbers.

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Hospital-based physicians are reimbursed under the same general system as is used in Medicare. Bills for services rendered are submitted as follows:

- All hospital-based physicians, including emergency room physicians, radiologists, and pathologists, will bill Medicaid on a CMS-1500 claim form, or assign their billing rights to the hospital, which shall bill Medicaid on a CMS-1500 claim form.
- Physician services personally rendered for individual patients will be paid only on a reasonable charge basis (i.e., claims submitted under an individual NPI on a physician claim form). This includes services provided by a radiologist and/or pathologist.
- Reasonable charge services are: 1) personally furnished for a patient by a physician; 2) ordinarily require performance by a physician and; 3) contribute to the diagnosis or treatment of an individual patient.

Off-site Mobile Physician Services

Off Site Mobile Physician's Services shall comply with all Medicaid rules and regulations as set forth in the State Plan, Alabama Medicaid Administrative Code, and Code of Federal Regulations including but not limited to the following requirements:

(a) Shall provide ongoing, follow-up, and treatment and/or care for identified conditions,
(b) Shall provide ongoing access to care and services through the maintenance of a geographically accessible office with regular operating business hours within the practicing county or within 15 miles of the county in which the service was rendered,
(c) Shall provide continuity and coordination of care for Medicaid recipients through reporting and communication with the Primary Medical Provider,
(d) Shall maintain a collaborative effort between the off-site mobile physician and local physicians and community resources. A matrix of responsibility shall be developed between the parties and available upon enrollment as an off-site mobile physician,
(e) Shall provide for attainable provider and recipient medical record retrieval,
(f) Shall maintain written agreements for referrals, coordinate needed services, obtain prior authorizations and necessary written referrals for services prescribed. All medical conditions identified shall be referred and coordinated, for example:
    (i) Eyeglasses,
    (ii) Comprehensive Audiological services,
    (iii) Comprehensive Opthalamological services,
(g) Shall not bill Medicaid for services which are offered to anyone for free. Provider shall utilize a Medicaid approved sliding fee scale based on Federal Poverty Guidelines,
(h) Shall ensure that medical record documentation supports the billing of Medicaid services, and
(i) Shall obtain signed and informed consent prior to treatment.

NOTE:
If a provider routinely accepts Medicaid assignments, he/she may not bill

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Medicaid or the recipient for a service he/she did not provide, i.e., "no call" or “no show”.

Locum Tenens and Substitute Physician Under Reciprocal Billing Arrangements

It is common practice for physicians to retain substitute physicians to take over their professional practices when the regular physicians are absent for reasons such as illness, pregnancy, vacation, or continuing medical education, and for the regular physician to bill and receive payment for the substitute physician’s services as though he/she performed them. The substitute physician generally has no practice of his/her own and moves from area to area as needed. The regular physician generally pays the substitute physician a fixed amount per diem, with the substitute physician having the status of an independent contractor rather than of an employee. The substitute physicians are generally called “locum tenens” physicians.

Reimbursement may be made to a physician submitting a claim for services furnished by another physician in the event there is a reciprocal arrangement. The regular physician shall identify the services as substitute physician services by entering HCPCS modifier **Q5** (Service Furnished by a Substitute Physician under a Reciprocal Arrangement) or HCPCS modifier **Q6** (Service Furnished by a Locum Tenens Physician) after the procedure code. The reciprocal arrangement may not exceed 14 days in the case of an informal arrangement. Effective for claims submitted on or after June 15, 2012, the reciprocal arrangement may not exceed 60 continuous days in the case of an arrangement involving per diem or other fee-for-time compensation. Both providers participating in a reciprocal arrangement must be enrolled with the Alabama Medicaid Agency. The regular physician should keep a record on file of each service provided by the substitute physician and make this record available to Medicaid upon request. Claims will be subject to post-payment review. Please refer to section 28.6.3 Procedure Codes and Modifiers for information regarding modifiers Q5 and Q6.

Pharmacy Quantity Limitations and Controlled Substances

The pharmacist or prescriber must request an override when the prescription exceeds Medicaid’s maximum limit allowed per month. The prescriber should not write separate prescriptions, one to be paid by Medicaid and one to be paid as cash, to circumvent the override process. For further information on pharmacy quantity limitations and prescriptions for controlled substances, refer to Chapter 27, section 27.2.3 “Quantity Limitations”.

NOTE:

In accordance with Section 5042 of the SUPPORT Act, effective October 1, 2021, prescribers of Medicaid eligible recipients are required to check the Alabama PDMP (Prescription Drug Monitoring Program) prior to prescribing a Schedule II controlled substance. If the prescriber does not check the PDMP, the prescriber is required to document the reason in the medical record. Exclusions to this requirement include prescriptions written for hospice patients, patients with an active cancer diagnosis, residents of a long term care nursing facility, and children under the age of

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18(Schedule II prescriptions for ADHD only).

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 is a person who is a graduate of an approved program, is licensed by the Board of Medical Examiners (BME) of the State of Alabama, and is registered by the BME to perform medical services under the supervision of a physician approved by the BME to supervise the assistant.

All services requiring additional education and training beyond the scope of practice billed by a CRNP/PA must be documented in the approved collaborative agreement from the BME and the Alabama Board of Nursing (ABN) between the practitioner and physician. The only exception is for those "routine" services within the scope of practice approved by the applicable licensing and governing boards. Services billed outside a CRNP/PA scope of practice and/or collaborative agreement are subject to post-payment review.

Medicaid may make payment for services of PAs and CRNPs who are legally authorized to furnish services and who render the services under the supervision and collaboration 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 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 unsupervised practice by PAs or CRNPs.

The PA or CRNP **must enroll with the Alabama Medicaid Agency** with a valid NPI number and employing physician as the payee.

Covered services furnished by the PA or CRNP must be billed under the PA's or CRNP's name and NPI as the rendering provider.

The office visits performed by the PA or CRNP will count against the recipient's yearly benefit limitation.

The PA or CRNP may make physician-required visits to nursing facilities.

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The PA or CRNP may not make physician-required inpatient visits to hospitals or other institutional settings to qualify for payment to the physician or to satisfy current regulations as physician visits.

Effective August 01, 2018, an initial prescription or order for home health services and certain medical supplies, equipment and appliances must be signed by a physician.

Refer to Chapter 14 – Durable Medical Equipment (DME), supplies, Appliances, Prosthetics, Orthotics and Pedorthics (POP) for more information on the requirements for the initial written prescription/order for certain medical supplies, equipment, and appliances.

Refer to Chapter 17 – Home Health for more information on the requirements for placing the initial written prescription/order for home health services.

Refer to Chapter 21 – Certified Registered Nurse Practitioner (CRNP) and Physician Assistant (PA) for additional information. Information regarding Independent CRNPs is also found in this chapter. For more specific information on coverage, you may call the Provider Assistance Center at 1-800-688-7989.

28.2.2 Covered Services

In general, Medicaid covers physician services if the services meet the following conditions:

- Considered medically necessary by the attending physician
- Designated by procedure codes in the Physicians' Current Procedural Terminology (CPT), or HCPCS. The table below contains details on selected covered services.

Consistent with the implementation of the mandated Medicaid NCCI edits effective November 9, 2010. Refer to this link, https://www.medicaid.gov/medicaid/program-integrity/national-correct-coding-initiative-medicaid/index.html for more information regarding NCCI.

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Abdominoplasty	Medical necessity criteria must be met and Prior Authorization obtained, or the procedure will be considered cosmetic and will not be covered. See Chapter 4, Obtaining Prior Authorization.
Add-on Code	Add-on Code definition in the CPT is recognized and allowed for payment with the appropriate primary code.
Administration Fee	Please refer to Appendix H, Medicaid Physician Administered Drugs, section H.1 (Policy) for information regarding office visits, chemotherapy, and administration fees. When an Evaluation and Management service is provided *and* a Drug Administration code (96372, 96373, 96374, 96375, and 96376) is provided at the same time, the E&M code, Drug Administration Code, and the HCPCS Code for the drug may be billed. A **Significant Separately Identifiable Service** must be performed in conjunction with the Drug Administration code for consideration of payment for the E&M Code. A **Modifier 25** must be appended to the E&M service for recognition as a "**Significant Separately Identifiable Service".** Medical Record documentation must support the medical necessity of the visit as well as the level of care provided. However, when no **Significant Separately Identifiable** E&M service is actually provided at the time of a Drug Administration, an E&M code should not be billed. In this instance, the Drug Administration Code and the HCPCS Code for the drug may be billed. An example of this is routine monthly injections like B-12, iron, or Depo-Provera given on a regular basis without a **Significant Separately Identifiable** E&M service being provided. These services will be subject to post payment review. Please refer to Appendix A, Well Child Check-Up, Section A.6.1 (Fees) for information regarding the use of designated VFC codes for billing immunization administration fee(s).
Allergy Treatments	Please refer to Appendix H, Medicaid Physician Administered Drugs for information.
Applied Behavior Analysis (ABA)Therapy	ABA therapy is covered. See Chapter 37 – Therapy.
Anesthesia	Anesthesia is covered. See Chapter 38, Anesthesiology.
Artificial Eyes	Artificial eyes must be prescribed by a physician. Refer to Chapter 15, Eye Care Services for specific coverage information.
Bariatric Procedures	Considered cosmetic unless specific medical criteria are met and with Prior Authorization. Bariatric surgical procedures are considered for Medicaid eligible recipients between 18 and 64 years of age, effective June 1, 2009. Bariatric surgery for recipients who are under 18 years old and who have one or more immediate life-threatening co-morbidities will be considered for authorization on a case-by-case basis by the Medical Director, effective March 1, 2014. See Chapter 4, Obtaining Prior Authorization.
Breathing or Inhalation Treatments	Breathing or inhalation treatments are a covered service. Any medication provided during a breathing treatment (e.g., Albuterol) is considered a component of the treatment charge. EXCEPTION: See Appendix H related to coverage of J2545 Pentamidine Isethionate.
Cardiac Catheterization	Cardiac Catheterization codes may be subject to the multiple procedure/surgery reductions.

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Cerumen Removal	CPT code 69210 is a covered service. **Payment may be made for impacted cerumen** (when **ALL** of the following are met): 1) the service is the sole reason for the patient encounter, 2) the service is personally performed by the physician or non-physician practitioner (i.e. nurse practitioner, physician assistant), 3) the service is provided to a patient who is symptomatic, and 4) the documentation illustrates significant time and effort spent in performing the service. Effective January 1, 2014, CPT code 69210 is a unilateral procedure. Please refer to section 28.6.3 for billing of bilateral procedures. **Payment consideration may be made for both the procedure and the E&M services** if **ALL** of the following conditions exist: 1) The nature of the E&M visit is for something other than removal of impacted cerumen. 2) During an unrelated patient encounter (visit), a specific complaint or condition related to the ear(s) is either discovered by or brought to the attention of the physician/non-physician practitioner by the patient. 3) Otoscopic examination of the tympanic membrane is not possible due to a cerumen obstruction in the canal. 4) The removal of impacted cerumen requires the expertise of a physician or non-physician practitioner. 5) The procedure requires a significant amount of the physician'/non-physician practitioner's effort and time. 6) Documentation is present in the patient record to identify the above criteria have been met. **Limitations**: • Removal of impacted cerumen performed by someone other than the physician or non-physician practitioner is not billable. • Simple cerumen removal performed by the physician or office personnel (e.g., nurses, office technicians) is not medically necessary and therefore, not separately payable. • An E&M service and the removal of impacted cerumen are not separately payable when the sole reason for patient encounter is for the removal of impacted cerumen. • The patient is asymptomatic (e.g. denies pain, hearing loss, vertigo. etc.). • Visualization aids such as, but not necessarily limited to, binocular microscopy, are considered to be included in the reimbursement for 69210 and should not be billed separately. Most patients do not require medically necessary disimpaction of cerumen by a physician. Patients who require this service more often than 3-4 times per year would be unusual. **NOTE: CPT 69210 requires a prior authorization and is restricted to ages 0-20 in the outpatient hospital setting.
Chemotherapy Administration	When an Evaluation and Management service is provided *and* a Hydration, Therapeutic, Prophylactic, Diagnostic and Chemotherapy Administration code is provided at the same time, the E&M code, Drug Administration Code, and the HCPCS Code for the drug may be billed. A **Significant Separately Identifiable Service** must be performed in conjunction with these administration codes for consideration of payment for the Evaluation and Management Code. A **Modifier 25** must be appended to the E & M service for recognition as a **"Significant Separately Identifiable Service".** Procedure Code 99211 will not be allowed with a modifier 25 or when billed in conjunction with the above administration codes. Medical record documentation must support the medical necessity and level of care of the visit. These services are subject to post payment review.

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CT Scans	CT scans are covered as medically necessary. Effective for dates of service March 2, 2009, and thereafter, CT scans require prior authorization for coverage. See Chapter 4, Obtaining Prior Authorization, Chapter 19, Hospital and Chapter 22, Independent Radiology.
Chiropractors	Chiropractic services are covered only for QMB recipients and for services referred directly as a result of an EPSDT screening.
Chromosomal Studies	Medicaid can pay for these studies on prospective mothers in an effort to identify conditions that could result in the birth of an abnormal child.
Circumcision	Circumcision of newborns is a covered service. If medically necessary, non-newborn circumcision is covered. These services will be subject to post payment review.
Dental Varnishing	Refer to Chapter 13, Dentist for specific coverage information.
Developmental Testing Intensive Level (Multi-disciplinary Team only)	Refer to Appendix A, Well Child Check-Up (EPSDT) for specific coverage information.
Diet Instruction	Diet instruction performed by a physician is considered part of a routine visit.
Drugs	Refer to Appendix H, Physician Drug List for coverage information.
Endovenous **Laser** Ablation of Varicose Veins, Endoluminal **Radiofrequency** Ablation of Saphenous Varicose Veins, Sclerotherapy, and Ambulatory phlebectomy	The following procedure codes require prior authorization before services are rendered to a recipient: 1. Procedure codes**36478** (Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, **laser**; first vein treated) and **Add on** code **36479** (second and subsequent veins treated in a single extremity, each through separate access sites) should only be billed along with the primary code (36478). 2. Procedure codes **36475** (Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, **radiofrequency**; first vein treated, and **Add on** code **36476** (second and subsequent veins treated in a single extremity, each through separate access sites) should only be billed along with the primary code (36475). 3. **Effective 1/1/2013**, the following procedure codes will require prior authorization: **36470** (Injection of **sclerosing** solution; single vein), **36471** (multiple veins, same leg), **37765** (Stab **phlebectomy** of varicose veins, 1 extremity; 10-20 stab incisions), and **37766** (more than 20 incisions). ** **These procedures are not covered for cosmetic purposes.**
Eustachian Tube Inflation	Effective 8/25/2008, only physicians with specialties of EENT and Otorhinolaryngology may bill eustachian tube inflation, transnasal; with catherization (69400), without catheterization (69401).
Examinations	Physician visits for examinations are counted as part of each recipient's benefit limit of 14 physician visits per year. Exception: Certified Emergencies. Office visits are limited to one per day, per recipient, per provider. For purposes of this limitation, a physician or physician of the same specialty and subspecialty from the same group practice are considered a single provider. Annual routine physical examinations are not covered except through EPSDT. Refer to Appendix A, EPSDT, for details. Medical examinations for such reasons as insurance policy qualifications are not covered. Physical examinations for establishment of total and permanent disability status if considered medically necessary are covered. Medicaid requires a physician's visit once every 60 days for patients in a nursing facility. Patients in intermediate care facilities for the individuals with intellectual disabilities must receive a complete physical examination at least annually.

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Eyecare	Eye examinations by physicians are a Medicaid covered service. Physician visits for eye care disease are counted as part of each recipient's benefit limit of 14 physician visits per year.
Foot Devices	See Chapter 14, Durable Medical Equipment (DME), for details
Gastric bypass	Covered with prior authorization approval when specific medical criteria are met. See Chapter 4, Obtaining Prior Authorization.
Hearing Aids	See Chapter 10, Audiology/Hearing Services, for details.
Hyperbaric Oxygen Therapy	Topically applied oxygen is not hyperbaric and is not covered. HBO therapy should not be a replacement for other standard successful therapeutic measure. Medical necessity for the use of hyperbaric oxygen for more than two months must be prior approved. (Chapter 4, Obtaining Prior Authorization). Refer to Chapter 19 Hospital, under Outpatient Hyperbaric Oxygen Therapy (HBO) for specific coverage information.
Hyperalimention Parental TPN IDPN IPN	Please refer to Section 28.2.9 for documentation requirements for parental, TPN, IDPN, and IPN nutrition.
Immunizations	Refer to Appendix A, EPSDT, for information regarding the Vaccines For Children (VFC) Program. Payment for immunizations against communicable diseases for adults will be made if the physician normally charges his patients for this service. Refer to Appendix H, Alabama Medicaid Physician Administered Drugs for coverage information.
Infant Resuscitation	Newborn resuscitation (procedure code 99465 on/after 01/01/09) is a covered service when the baby's condition is life threatening and immediate resuscitation is necessary to restore and maintain life functions. Intubation, endotracheal, emergency procedure (procedure code 31500) cannot be billed in conjunction with newborn resuscitation.
Long Acting Reversible Contraception (LARC)	Effective for dates of service April 1, 2014, and thereafter, Alabama Medicaid will cover long acting birth control in the inpatient hospital setting after a delivery for postpartum women or in an outpatient setting after discharge from the inpatient hospital. Refer to Chapter 19, Hospital for additional information.
Mammography Diagnostic	Refer to Chapter 22, Independent Radiology for coverage information.
Mammography Screening	Refer to Chapter 22: Independent Radiology for coverage information.
Medical Materials and Supplies	Costs for medical materials and supplies normally utilized during office visits or surgical procedures are to be considered part of the total fee for procedures performed by the physician and therefore are not generally a separately billable service.
Medical Necessity	The Alabama Medicaid Agency is mandated to only reimburse for services, procedures, and surgeries that are medically necessary. Refer to Chapter 7, Understanding Your Rights and Responsibilities as a Provider for general criteria on Medical Necessity/ Medically Necessary Care. Medical necessity must be clearly documented in the recipient's medical record with supporting documentation such as: Laboratory test results, diagnostic test results, history (past attempts of management if applicable), signs and symptoms, etc. All Medicaid services are subject to retrospective review for medical necessity. EXAMPLE: Endometrial Ablation is covered by Medicaid when it is considered medically necessary and should not be performed when an alternative outcome is intended such as cessation of menses.
Nerve Conduction Studies and Electromyography	Refer to Chapter 22, Independent Radiology for coverage information.

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Newborn Claims	Five kinds of newborn care performed by physicians in the days after the child's birth when the mother is still in the hospital may be filed under the mother's name and number or the baby's name and number: When billing under the mother's Medicaid number, use diagnosis codes **V200 – V202 for ICD-9 or Z76.1-Z76.2 and Z00.129 for ICD-10 only, for normal newborn care. These diagnosis codes must be used on the claim form for consideration of payment.** 1. Routine newborn care (99460 on/after 01/01/09, 99462 on/after 01/01/09, and discharge codes 99238 or 99239). 2. Circumcision (54150 or 54160) Please note that the billing of PC 64450 is not allowed along with PC 54150 (which includes the nerve block in the description). 3. Newborn resuscitation (99465). 4. Standby services following a cesarean section or a high-risk vaginal delivery (99360). 5. Attendance at delivery (when requested by delivering physician) and initial stabilization of newborn (99464). Standby services (procedure code 99360) are covered only when the pediatrician, family practitioner, neonatologist, general practitioner, or non-delivering OB/GYN is on standby in the operating or delivery room during a cesarean section or a high-risk vaginal delivery. Attendance of the standby physician in the hospital operating or delivery room must be documented in the operating or delivery report. Use CPT codes when filing claims for these five kinds of care. If these services are billed under the mother's name and number and the infant(s) are twins, indicate Twin A or Twin B in Block 19 of the claim form. Any care other than routine newborn care for a well-baby, before and after the mother leaves the hospital, must be billed under the child's name and number.
Newborn Hearing Screening	Inpatient newborn hearing screenings are considered an integral part of inpatient hospital services. Please refer to Chapter 19 for Outpatient Services. Limited hearing screen codes 92586 and 92587 (CPT 2002) may be billed in an outpatient setting provided: 1) an infant was discharged prior to receiving the inpatient hearing screen, or 2) an infant was born outside a hospital or birthing center. These codes are reimbursable for audiologists, pediatricians, otolaryngologists, and EENT. Comprehensive hearing screen codes 92585/92588/92558 may be billed for: 1) infants who fail the newborn hearing screening prior to discharge from the hospital, or 2) infants/children fail a hearing screening at any time following discharge. Comprehensive hearing screenings should be performed on infants by three months of age if they failed the newborn hearing screening prior to discharge. Code 92585 is reimbursable for otolaryngologists, audiologists, pediatricians, and EENT. Code 92588 is reimbursable for otolaryngologists, audiologists, pediatricians, EENT, and neurologists.
Obstetrical Services	Refer to Section 28.2.11
Obstetrical Ultrasounds	Effective 10/1/2019, Medicaid no longer requires prior authorization for obstetrical ultrasounds. All ultrasounds must be medically necessary with medical diagnosis documented supporting the benefit of the ultrasound procedure. DHCPs should refer to Chapter 40 for details regarding care coordination.
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.

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Post-Surgical Visits	Routine post-surgical care in the hospital or office visits for conditions directly related to major surgical procedures are covered by the surgical fee. Post-surgical visits cannot be billed separately the day of, or up to 90 days after surgery. For conditions unrelated to the surgical procedure bill the appropriate (E&M) procedure code with a 24 modifier appended. The diagnosis must support use of the modifier 24.
Prosthetic Devices	Internal prosthetic devices (e.g., Smith Peterson Nail or pacemaker) are a covered benefit.
Psychiatric Services	Physician visits for psychiatric services are counted as part of each recipient's benefit limit of 14 physician visits per year. Psychiatric evaluation or testing are covered services under the Physicians' Program if services are rendered by a physician in person and are medically necessary. Psychiatric evaluations are limited to one per calendar year, per provider, per recipient. Psychotherapy visits are included in the office visit limit of 14 visits per calendar year. Effective January 1, 2013, the following psychotherapy Add-on codes may be billed in conjunction with Evaluation and Management codes billed by the psychiatrist: 90833, 90836, and 90838. Psychiatric services under the Physicians' Program are confined to use with psychiatric diagnosis (290-319 for ICD-9 and F0150-F99 for ICD-10 and must be performed by a physician. The "must be performed by a physician" does not apply for EPSDT-referred psychiatric services. Hospital visits are not covered when billed in conjunction with psychiatric therapy on the same day. For EPSDT-referred services rendered by psychologist, see Chapter 34 for details. Psychiatric day care is not a covered benefit under the Physicians' Program. **NOTE**: For billing purposes, psychiatrist services are not limited to what psychologist bills.
Radiation Treatment Management	Radiation treatment management services do not need to be furnished on consecutive days. Up to two units may be billed on the same date of service as long as there has been a separate break in therapy sessions.
Second Opinions	Physician visits for second opinions are counted as part of each recipient's benefit limit of 14 physician visits per year. Optional Surgery: Second opinions (regarding non-emergency surgery) are highly recommended in the Medicaid program when the recipients request them. Diagnostic Services: Payment may be made for covered diagnostic services deemed necessary by the second physician.
Self-inflicted injuries	Self-inflicted injuries are covered.
Sleep Studies	Covered when billed through the enrolled physician's NPI or Outpatient hospital NPI. Medicaid does not enroll sleep study clinics. Unattended sleep studies (95806) are not covered by Medicaid. Please refer to Chapter 19, Hospital, for additional limitations.

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Surgery	Cosmetic surgery is covered only when prior approved for medical necessity. Examples of medical necessity include prompt repair of accidental injuries or improvement of the functioning of a malformed body member. Elective surgery is covered when medically necessary. **Multiple surgeries are governed by the following rules:** When multiple or bilateral surgical procedures that add significant time or complexity are performed at the same operative session, Medicaid pays for the procedure with the highest allowed amount and half of the allowed amount for each subsequent procedure. This also applies to laser surgical procedures. Additional payments will **not** be made for procedures considered to be mutually exclusive or incidental. Mutually Exclusive procedures are services that cannot reasonably be performed at the same anatomic site or same patient encounter. Certain procedures are commonly carried out as integral parts of a total service and as such do not warrant a separate charge. When incidental procedures (e.g., excision of a previous scar or puncture of an ovarian cyst) are performed during the same operative session, Medicaid reimburses for the major procedure only. CPT defined Add-on codes are considered for coverage when billed with the appropriate primary procedure code. Add-on codes are not subject to rule of 50 percent reduction. Any dressing/compression wrap performed in conjunction with wound debridement is considered part of the debridement services and is not separately covered/billable. Laparotomy is covered when it is the only surgical procedure performed during the operative session or when performed with an unrelated or incidental surgical procedure. Surgeons performing laparoscopic procedures on recipients where a laparoscopic procedure code (PC) has not been established should bill the most descriptive PC with modifier 22 (unusual procedural services) until the new PC is established. Unlisted CPT codes require prior authorization **before** services are rendered. Whenever unusual procedures are performed and there is no exact descriptive CPT code, the Alabama Medicaid Agency requires the most appropriate CPT code be utilized with a modifier 22. Procedure Code 69990 Operating Microscope may be paid separately only when submitted with the following CPT codes: 61304-61546, 61550-61619, 61624-61626, 61640-61711, 62010-62100, 63081-63308, 63704-63710, 64831, 64834-64836, 64840-64858, 64861-64870, 64885-64898, 64905-64907. Certain relatively small surgical procedure codes designated as “zero” global days may be billed in addition to an office visit. Additionally, these codes do not carry the global surgical package concept of inclusion of post-operative care. It is necessary to append the appropriate anatomical modifiers to surgical codes to differentiate between multiple surgeries and sites. Please refer to Section 28.6.3 Procedure Codes and Modifiers. Modifier 57 (Decision for Surgery), is not billable on the same day of surgery. NOTE: Surgeons are responsible for digital submission of consent forms and supporting documentation for hysterectomy and sterilization consent forms. Please refer to Section 28.6.7 of this chapter.

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Surgery, Breast Reconstruction	Breast reconstruction surgery is reimbursable following a medically necessary mastectomy when performed for the removal of cancer. Breast reconstruction will also be allowed on the non-cancerous contra lateral breast for the purpose of symmetry. Medicaid does **not** reimburse for reconstruction after a prophylactic mastectomy unless evidence of breast cancer is documented in the medical record. All reconstructive procedures require prior authorization. The term "reconstruction" shall include augmentation mammoplasty, reduction mammoplasty, and mastoplexy. Breast reconstruction surgeries are governed by the following rules: • The reconstruction follows a medically necessary mastectomy for the removal of cancer. A pathology report is required. • The recipient is eligible for Medicaid on the date of reconstruction surgery • The recipient elects reconstruction within two years of the mastectomy surgery date • Documentation of therapy completion (chemotherapy and/or radiation treatment), and Operative Report of mastectomy if reconstructive procedure is performed after mastectomy on a different date. If reconstructive procedures are to be performed on the same date as the mastectomy, the physician must send certification that radiation therapy is not planned based on current staging or treatment plan, or must document therapy completion. • For more information regarding prior authorization, please refer to Chapter 4 Obtaining Prior Authorization. For more information related to breast prosthesis, please refer to Chapter 14 Durable Medical Equipment.
Telemedicine	Refer to Chapter 112, Telemedicine Service, for coverage details.
Therapy	Physician visits for therapy are counted as part of each recipient's benefit limit of 14 physician visits per year. See Rule No. 560-X-6.14 for details about this benefit limit in the *Alabama Medicaid Agency Administrative Code,* Chapter 6. Physical Therapy is not covered when provided in a physician's office. Physical therapy is covered only when prescribed by a physician or non-physician practitioner and provided in a hospital setting. Refer to Chapter 19, Hospital, for more information. For all physical therapy services performed as a result of an EPSDT screening refer to Chapter 37, Therapy, for policy only. Group Therapy is a covered service when a psychiatric diagnosis is present and the therapy is prescribed, performed, and billed by the physician personally. Group Therapy is not covered when performed by a caseworker, social services worker, mental health worker, or any counseling professional other than physician. Group Therapy is included in the physician visit limit of 14 visits per year. Speech Therapy for a speech related diagnosis, such as stroke (CVA) or partial laryngectomy, is a covered benefit when prescribed by and performed by a physician in his office. Speech therapy performed in an inpatient or outpatient hospital setting or in a nursing facility is a covered benefit, but is considered covered as part of the reimbursement made to the facility and should not be billed by the physician. Family Therapy is a covered service when a psychiatric diagnosis is present and the physician providing the service supplies documentation that justifies the medical necessity of the therapy for each family member. Family therapy is not covered unless the patient is present. Family Therapy is not covered when performed by a caseworker, social service worker, mental health worker, or any counseling professional other than a physician. Family Therapy is included in the physician visit limit of 14 visits per year.
Transplants	See Chapter 19, Hospitals, for transplant coverage.

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Ventilation Study	Ventilation study is covered if done in physician's office by the physician or under the physician's direct supervision. Documentation in the medical record must contain all of the following: • Graphic record • Total and timed vital capacity • Maximum breathing capacity Always indicate if the studies were performed with or without a bronchodilator.
Newborn Care Services	Well baby coverage is covered only on the initial visit, which must be provided within 8 weeks of birth. When the well-baby checkup is done, the physician should bill procedure code 99461. Diagnosis codes V20.2, V20.31 and V20.32 for ICD-9 and Z00.129. Z00.110 and Z00.111 for ICD-10 are acceptable to bill for routine newborn care/well baby checkup. Only one well-baby checkup can be paid per lifetime, per recipient. Refer to Appendix A, EPSDT, for information on additional preventive services.

NOTE:
For newborn hospital discharge services performed on a subsequent admission date, use code 99238. Please use code 99463 when filing claims for newborns assessed and discharged from the hospital or birthing room on the same date.

Coding Exceptions

Specific codes sets in an audit were identified with an explanation as to why they should be removed or modified in the audit process. Medicaid agrees these codes sets can be billed together as an exception to NCCI and/or CPT policy. As indicated, the multiple surgery rule will be applied.

Code Sets									***Multiple Surgery***
Procedure code 64450 is allowed with code 54160.									Yes
Tympanostomy 69436 – codes below									Yes
Allowed with 69436		21030	30545	31238	31511	31615	40819	42720	42831
11300	12052	21555	30801	31240	31515	31622	40820	42806	42835
11305	14040	21556	30802	31254	31525	31624	41010	42810	42836
11401	15120	30115	30901	31255	31526	31625	41110	42815	42870
11420	15760	30130	30903	31256	31535	31641	41115	42820	42960
11440	17000	30140	31000	31267	31540	38510	41520	42821	42961
11441	17017	30200	31020	31276	31541	38542	42140	42825	43200
11444	17250	30310	31231	31287	31575	38724	42145	42826	43202
11900	20922	30520	31237	31288	31613	40808	42200	42830	43830

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28.2.3 Non-covered Services

Service	*Coverage and Conditions*
Acupuncture	Acupuncture is not covered.
After Office Hours	The following services are not covered: After office hours, services provided in a location other than the physician's office, and office services provided on an emergency basis.
Autopsies	Autopsies are not covered.
Bariatric Procedures	Considered cosmetic unless specific medical criteria are met
Biofeedback	Biofeedback is not covered.
Blood Tests	Blood tests are not covered for marriage licenses.
Casting and Supplies	Some surgical codes are considered an inclusive package of professional services and/or supplies and are not considered separately allowable or reimbursable as the fracture repair or surgical codes is inclusive of these services. An example of this would be a surgical code for a fracture repair which is inclusive of any casting and strapping services or supplies.
Cerumen Removal	CPT Code 69210 is not covered if the ear wax is not impacted and the service does not meet the criteria outlined in section 28.2.2, Covered Services.
Chiropractors	Chiropractic services are not covered, except for QMB recipients and for services referred directly as a result of an EPSDT screening.
Chromosomal Studies	Chromosomal studies (amniocentesis) on unborn children being considered for adoption are not covered. Medicaid can pay for these studies on prospective mothers in an effort to identify conditions that could result in the birth of an abnormal child.
Dressing and Compression Wrap	Any dressing/compression wrap performed in conjunction with wound debridement is considered part of the debridement services and is not separately covered / billable.
Experimental Treatment or Surgery	Experimental treatment or surgery is not covered.
Filing Fees	Filing Fees are not covered.
Hypnosis	Hypnosis is not covered.
Laetrile Therapy	Laetrile therapy is not covered.
Mutually Exclusive Procedures	Mutually exclusive procedures are those codes that cannot reasonably be done in the same session and are considered not separately allowable or reimbursable. For example, a vaginal and abdominal hysterectomy on the same date of service.
Oxygen and Compressed Gas	Oxygen therapy is a covered service based on medical necessity and requires prior authorization. Please refer to Chapter 14, DME, for more information.
Pulse Oximetry	Effective January 1, 2009, Non-invasive ear or pulse oximetry services (procedure codes 94760-94762) will no longer be considered separately billable/payable by Medicaid for physician and outpatient services. These procedure codes, per policy dated July 2006, are considered bundled services which are included in Evaluation and Management codes for both physician and outpatient services.

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Surgery	When multiple and/or bilateral procedures are billed in conjunction with one another and meet the CPTs definition of "Format of Terminology" (bundled or subset) and/or comprehensive/component (bundled) codes, then the procedure with the highest allowed amount will be paid while the procedure with the lesser amount will not be considered for payment as the procedure is considered an integral part of the covered service. Please refer to Section 28.6.3 Procedure Codes and Modifiers. Incidental surgical procedures are defined as those codes that are commonly carried out as integral parts of a total service and as such do not warrant a separate charge. An example of this would be lysis of adhesions during the same session as an abdominal surgery. Refer to this link, https://www.medicaid.gov/medicaid/program-integrity/national-correct-coding-initiative-medicaid/index.html for more information regarding NCCI.
Post-Surgical Visits	Post-surgical hospital or office visits for conditions directly related to major surgical procedures are covered by the surgical fee. Surgical visits cannot be billed separately the day of surgery or up to 90 days after surgery. Visits by Assistant Surgeon or Surgeons are not covered.
Preventive Medicine	Medicaid does not cover preventive medicine other than those specified elsewhere, including but not limited to, EPSDT screening.
Syntocin	Syntocin is not covered.
Telephone Consultations	Telephone consultations are not covered.
Therapy	Occupational and Recreational Therapies are not covered.

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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 limited to): EPSDT, prenatal care, postnatal care, and family planning.
- Recipients receiving cancer treatment during the calendar year are eligible for additional annual physician office visits (*see Cancer Treatment Visits section below).
- Physicians services provided in a hospital outpatient setting that have been certified as an emergency do not count against the physician benefit limit of 14 per calendar year.
- If a patient receives ancillary services in a doctor's office, by the physician or under his/her direct supervision, and the doctor submits a claim only for the ancillary services but not for the office visit, then the services provided will not be counted as a visit.

Office visits are limited to one per day per recipient per provider. For purposes of this limitation, a physician or physician of the same specialty and subspecialty from the same group practice are considered a single provider. Annual office visit benefit limits are 14 office visits per calendar year. Medicaid will continue to pay covered ancillary services (injections, lab, x-rays etc.…) for recipients after they have exhausted the 14 physician office visit limitation.

For further information regarding outpatient maintenance dialysis and ESRD, refer to Chapter 35, Renal Dialysis Facility.

A new patient office visit codes shall not be paid to the same physician or same group practice for a recipient more than once in a three-year period.

Cancer Treatment Visits

Effective January 1, 2023, Alabama Medicaid will increase the annual physician office visit maximum to 32 for Medicaid recipients receiving cancer treatment during the calendar year (January -- December). This increase will be available for each calendar year in which the recipient is receiving cancer treatment and is applicable for all cancers.

To qualify for this increase in annual physician office visits:

1. The claim must include one of the following informational procedure codes to identify the treatment stage:
   - 3300F: American Joint Committee on Cancer (AJCC) state documented and reviewed (ONC)
   - 3301F: Cancer stage documented in medical record as metastatic and reviewed (ONC)
   - S0353: Treatment planning and care coordination management for cancer initial treatment
   - S0354: Treatment planning and care coordination management for cancer established patient with a change in regimen

(Failure to provide one of the required informational procedure codes will cause the recipient to not be eligible for the 32 visits.)

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2. A cancer diagnosis, within the current calendar year, must be in the recipient's claims history.

Additionally, medical documentation to support the diagnosis and treatment(s) must be maintained in the recipient's record and provided to the Agency, upon request, in the event of audit.

Prolonged Services Direct Patient Contact in Office or Other Outpatient Setting and Hospital Setting

Effective January 1, 2023, the procedure codes for prolonged services have changed. Procedure code G2212 will be used for the office or other outpatient setting, and procedure code G0316 will be used for the hospital setting.

- **Documentation Requirement**: When prolonged time occurs, the appropriate prolonged services code may be reported. The total time on the date of the encounter spent caring for the patient should be documented in the medical record when it is used as the basis for code selection. Time must be documented clearly in the medical record to indicate the beginning of service time and the end of service time to justify these codes being billed in addition to the office visit.

    1. Physician or other qualified health care professional time includes the following activities, when performed:
        - preparing to see the patient (e.g., review of tests)
        - obtaining and/or reviewing separately obtained history
        - performing a medically appropriate examination and/or evaluation
        - counseling and educating the patient/family/caregiver
        - ordering medications, tests, or procedures
        - referring and communicating with other health care professionals (when not separately reported)
        - documenting clinical information in the electronic or other health record
        - independently interpreting results (not separately reported) and communicating results to the patient/family/caregiver
        - care coordination (not separately reported)
    2. Do not count time spent on the following:
        - the performance of other services that are reported separately
        - travel
        - teaching that is general and not limited to discussion that is required for the management of a specific patient

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- When filing claims, procedure codes G2212 or G0316 are assigned only when the code for the primary E&M service has been selected based solely on total time, and only after exceeding by 15 minutes the maximum time that is required to report the highest-level service. For example, when reporting an established patient encounter (99215), code G2212 would not be reported until at least 15 minutes of time beyond 54 minutes has been accumulated (i.e., 69 minutes) on the day of the encounter. **Do not report G2212 or G0316 for any time unit less than 15 minutes. The maximum allowed billable units is 4 at 15 minute intervals.**

  1. G2212 and G0316 must be billed in conjunction with companion procedure codes:

     - G2212 must be filed with 99205 or 99215 for office or other outpatient E&M services.
     - G0316 must be filed with 99223, 99233, or 99236 for hospital inpatient or observation care E&M services.

  2. These services will be subject to post-payment review.

28.2.5 Physician Services to Hospital Inpatients

In addition to the 14 physician visits, Medicaid covers up to 16 inpatient dates of service per physician, per recipient, per calendar year. For purposes of this limitation, each specialty within a group or partnership is considered a single provider. Physician visits are limited to one per day.

When filing claims for recipients enrolled in the ACHN Program, refer to Chapter 40.

Physician hospital visits are limited to one visit per day, per recipient, per provider.

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

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

- Echocardiography (i.e., M-mode, transthoracic, complete and follow up)
- Echocardiography (i.e., 2D, transesophageal)

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- Echocardiography (i.e., Doppler pulsed or continuous wave with spectral display, complete and follow up)
- Cardiac Catheterizations
- Comprehensive electrophysiologic evaluations and follow up testing
- Programmed stimulation and pacing
- Intra-operative epicardial and endocardial pacing and mapping
- Intracardiac catheter ablations; intracardiac echocardiography
- Evaluation of cardiovascular function
- Plethysmography, total body and tracing
- Ambulatory blood pressure monitoring
- Cerebrovascular arterial studies, extremity arterial studies, venous studies, and visceral and penile studies
- Circardian respiratory pattern recording (i.e., pediatric pneumogram), infant
- Needle electromyography
- Ischemic limb exercise test
- Assessment of aphasia
- Developmental testing
- Neurobehavioral status exam and neuropsychological testing battery

Professional interpretations for lab and x-ray (CPT code 70000 through 80000 services) in the inpatient setting can only be billed by pathologists and radiologists. The only exception is for professional interpretations by cardiologists for catheterization or arterial studies and for select laboratory procedures by oncologists and hematologists. Professional interpretations/components done by other physicians for services in this procedure code range are included in the hospital visit if one is done. If no hospital visit is made, professional interpretation by physicians other than radiologists, pathologists, oncologists, hematologists, and cardiologists should not be billed as these services are covered only for the above-mentioned specialties.

A physician hospital visit and hospital discharge shall not be paid to the same physician on the same day. If both are billed, only the discharge shall be paid.

Professional interpretations performed for an inpatient are counted by dates of service rather than the number of interpretation performed.

An office visit shall not be paid to the same provider or other physicians in the same group practice with the same specialty and subspecialty on the same day as an inpatient visit. If both are billed, then the **first** Procedure Code billed will be paid.

Physician consults are limited to one per day per recipient.

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28.2.6 Critical Care (99291 & 99292)

When caring for a critically ill patient, for whom the constant attention of the physician is required, the appropriate critical care procedure code (99291 and 99292) must be billed. Critical care guidelines are defined in the Current Procedural Terminology (CPT) and Provider Manual. Critical care is considered a daily global inclusive of all services directly related to critical care.

Coverage of critical care may total no more than four hours per day.

The actual time period spent in attendance at the patient's bedside or performing duties specifically related to that patient, irrespective of breaks in attendance, must be documented in the patient's medical record.

RESTRICTIONS:

No individual procedures related to critical care may be billed in addition to procedure codes 99291 and 99292, except:

- An EPSDT screening may be billed in lieu of the initial hospital care (P/C 99221, 99222, or 99223). If screening is billed, the initial hospital care cannot be billed.
- Procedure code 99082 (transportation or escort of patient) may also be billed with critical care (99291 and/or 99292 for recipients 25 months of age and older or 99466 and/or 99467 for recipients 24 months of age or less). Only the attending physician may bill this service and critical care. Residents or nurses who escort a patient may not bill either service.

LIMITATIONS:

PROCEDURE CODES NOT BILLABLE IN ADDITION TO CRITICAL CARE (99291 & 99292):

FROM	TO	FROM	TO	FROM	TO	FROM	TO
31500	31500	43752	43757	92265	92275	95925	95937
36000	36440	51100	51100	92280	92287	99090	99091
36468	36479	51701	51702	92920	93299	99170	99199
36510	36510	62270	62270	93303	93352	99460	99463
36555	36555	71010	71020	93561	93562		
36591	36591	82800	82820	93668	93799		
36600	36680	91105	91105	93875	94799		

- Procedure codes 99291, 99292, 99466 and 99467 may be billed by the physician providing the care of the critically ill or injured patient in place of service 41, Ambulance, if care is personally rendered by the physician providing the care of the critically ill or injured patient.

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28.2.7 Pediatric and Neonatal Critical Care

CPT Code	Description	Criteria
99468	Initial Inpatient Neonatal Critical Care, per day for the evaluation and management of a critically ill neonate, 28 days of age or less	Not valid for 29 days or older, can be billed by any physician provider type
99469	Subsequent Inpatient Neonatal Critical Care, per day for the evaluation and management of a critically ill neonate, 28 days of age or less	Not valid for ages 29 days or older, can be billed by any physician provider type
99471	Initial Inpatient Pediatric Critical Care, per day for the evaluation and management of a critically ill infant or young child, 29 days through 24 months of age	Not valid for 28 days or less, can be billed by any physician provider type
99472	Subsequent Inpatient Pediatric Critical Care per day, for the evaluation and management of a critically ill infant or young child, 29 days through 24 months of age	Not valid for ages 28 days or less, can be billed by any physician provider type
99475	Initial inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 2 through 5 years of age	May be billed by any physician provider type for infant or child, 2 through 5 years of age
99476	Subsequent inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 2 through 5 years of age	May be billed by any physician provider type for infant or child, 2 through 5 years of age

The pediatric and neonatal critical care codes (99468-99476) include management, monitoring and treatment of the patient, including respiratory, pharmacological control of the circulatory system, enteral and parenteral nutrition, metabolic and hematologic maintenance, parent/family counseling, case management services and personal direct supervision of the health care team in the performance of their daily activities.

The following criteria should be used as guidelines for the correct reporting of neonatal and pediatric critical care codes for the critically ill neonate/infant. Only one criterion is required to be classified as critically ill.

- Respiratory support by ventilator or CPAP
- Nitric oxide or ECMO
- Prostaglandin, Indotropin of Chronotropic or Insulin infusions
- NPO with IV fluids
- Acute Dialysis (renal or peritoneal)
- Weight less than 1,250 grams
- Acute respiratory distress in a pediatric admission requiring oxygen therapy with at least daily adjustment and FIO2>35% oxygen by oxyhood.

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RESTRICTIONS:

No individual procedures related to critical care may be billed in addition to procedure codes 99468-99476 except:

- Chest tube placement
- Pericardiocentesis or thoracentesis
- Intracranial taps
- Initial hospital care history and physical screen may be billed in conjunction with 99468.

  NOTE: One EPSDT screen for the hospitalization will encompass all diagnoses identified during the hospital stay for referral purposes. The EPSDT screen is considered apart of 99468. Pediatric and neonatal providers should enroll as EPSDT and ESPDT Referred providers and document the referral in the medical record in order to file subsequent claims as EPSDT referred services.
- Standby (99360), resuscitation (99465), or attendance at delivery (99464) may be billed in addition to critical care. Only one of these codes may be billed in addition to neonatal intensive care critical care codes.

LIMITATIONS:

- Pediatric, neonatal critical care codes and intensive (non-critical) low birth weight service codes are reported once per day per recipient.
- Subsequent Hospital Care codes (99231-99233) cannot be billed on the same date of service as neonatal critical care codes (99468-99476)
- Only one unit of critical care can be billed per child per day in the same facility. Medicaid pays the first claim received and denies subsequent claims (first in, first out policy).
- Critical care is considered to be an evaluation and management service. Although usually furnished in a critical or intensive care unit, critical care may be provided in any inpatient health care setting. Services provided which do not meet critical care criteria, should be billed under the appropriate hospital care codes. If a recipient is readmitted to the NICU/ICU, the provider must be the primary physician in order for NICU critical care codes to be billed again.
- Once the patient is no longer considered by the attending physician to be critical, the Subsequent Hospital Care codes (99231-99233) should be billed. Only one unit can be billed per day per physician regardless of specialty. Medicaid pays the first claim received and denies subsequent claims (first in, first out policy).
- Transfers to the pediatric unit from the NICU cannot be billed using critical care codes. Subsequent hospital care would be billed in these instances.

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- Global payments encompass all care and procedures that are included in the rate. Providers may not perform an EPSDT screen and refer to a partner or other physician to do procedures. All procedures that are included in the daily critical care rate, regardless of who performed them, are included in the global critical care code.
- Consultant care rendered to children for which the provider is not the primary attending physician must be billed using consultation codes. Appropriate procedures may be billed in addition to consultations. If, after the consultation the provider assumes total responsibility for care, critical care may be billed using the appropriate critical care codes as defined above. The medical record must clearly indicate that the provider is assuming total responsibility for care of the patient and is the primary attending physician for the patient.

28.2.8 Initial and Continuing Observation or Intensive Care Services

CPT Code	Description	Criteria
99477	Initial hospital care, per day for the evaluation and management of the neonate, 28 days of age or younger, which requires intensive observation, frequent interventions, and other intensive care services.	May only be billed by a neonatologist
99478	Subsequent intensive care, per day, for the evaluation and management of the recovering very low birth weight infant (present body weight less than 1500 grams)	May only be billed by a neonatologist
99479	Subsequent intensive care, per day, for the evaluation and management of the recovering very low birth weight infant (present body weight of 1500-2500 grams)	May only be billed by a neonatologist
99480	Subsequent intensive care, per day, for the evaluation and management of the recovering infant (present body weight of 2501-5000 grams)	May only be billed by a neonatologist

These codes are used to report care subsequent to the day of admission provided by a neonatologist directing the continuing intensive care of the very low birth weight infant who no longer meets the definition of being critically ill. Low birth weight services are reported for neonates less than 2500 grams who do not meet the definition of critical care but continue to require intensive observation and frequent services and intervention only available in an intensive care setting. Services provided to these infants exceed those available in less intensive hospital areas of medical floors. These infants require intensive cardiac and respiratory monitoring, continuous and/or frequent vital signs monitoring, heat maintenance, enteral and/or parenteral nutritional adjustments, laboratory and oxygen monitoring and constant observation by the health care team under direct supervision.

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Restrictions:

No individual procedures related to critical care may be billed in addition to procedure codes 99478-99480 except:

- Chest tube placement
- Pericardiocentesis or thoracentesis
- Intracranial taps

Limitations:

- Once the patient is no longer considered by the attending physician to be critical, the Subsequent Hospital Care codes (99231-99233) should be billed. Only one unit can be billed per day per physician regardless of specialty. Medicaid pays the first claim received and denies subsequent claims (first in, first out policy).
- Global payments encompass all care and procedures that are included in the rate. Providers may not perform an EPSDT screen and refer to a partner or other physician to do procedures. All procedures that are included in the daily critical care rate, regardless of who performed them, are included in the global critical care code.
- Consultant care rendered to children for which the provider is not the primary attending physician must be billed using consultation codes. Appropriate procedures may be billed in addition to consultations. If, after the consultation the provider assumes total responsibility for care, critical care may be billed using the appropriate critical care codes as per the setting. The medical record must clearly indicate that the provider is assuming total responsibility for care of the patient and is the primary attending physician for the patient.
- Pediatric, neonatal critical care codes and intensive (non-critical) low birth weight services codes are only reported once per day per recipient.

PROCEDURE CODES NOT BILLABLE IN ADDITION TO INITIAL AND CONTINUING OBSERVATION OR INTENSIVE CARE SERVICES

FROM	TO	FROM	TO	FROM	TO	FROM	TO
31500	31579	62263	62368	94002	94004	99218	99220
36000	36830	90470	90471	94010	94772	99231	99239
43752	43761	90760	90781	95831	95857	99251	99275
51000	51010	92081	92081	95880	95882	99291	99292
51100	51102	92551	92551	96101	96125	99431	99435
51600	51798	92950	92950	96360	96379	99460	99463
53670	53675	93000	93352	99090	99091		

28.2.9 End-Stage Renal Disease (ESRD)

Physician services rendered to each outpatient maintenance dialysis patient provided during a full month shall be billed on a monthly capitation basis using the appropriate procedure code by age as outlined in the CPT.

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Monthly maintenance dialysis payment (i.e., uninterrupted maintenance dialysis) is comprehensive and covers most of a physician's services whether a patient dialyzes at home or in an approved ESRD outpatient facility. Dialysis procedures are allowed in addition to the monthly maintenance dialysis payment. In general, the Agency follows Medicare guidelines related to monthly capitation payments for physicians.

Physician services included in the monthly capitation payment for ESRD related services include, but are not limited to:

- Assessment and determination of the need for outpatient chronic dialysis therapy
- Assessment and determination of the type of dialysis access and dialyzing cycle,
- Management of the dialysis visits including outpatient visits for evaluation and management, management during the dialysis, and telephone calls.
- Assessment and determination if a recipient meets preliminary criteria as a renal transplant candidate including discussions with family members
- Assessment for a specified diet and nutritional supplementation for the control of chronic renal failure, including specifying quantity of total protein, sodium, potassium, amount of fluids, types of anemia and appropriate treatments, type of arthropathy or neuropathy and appropriate treatment or referral, estimated ideal dry weight, etc. Assessment for diabetic patient's diet and caloric intake is included also.
- Prescribing the parameters of intradialytic management including anticoagulant, dialysis blood flow rates and temperature, duration and frequency of treatments, etc.

The monthly capitation payment is limited to once per month, per recipient, per provider.

The following services are not covered by the monthly capitation payment (MCP) for the attending dialysis physicians and are reimbursed in accordance with usual and customary charge rules:

- Declotting of shunts
- Covered physician services furnished to hospital inpatients by a physician who elects not to receive the MCP for these services. For example, an attending physician who provides evaluation and management (E & M) services for a renal patient in an inpatient setting may bill appropriate CPT hemodialysis procedures in lieu of certain other E & M services for inpatient visits.

Nonrenal related physician services furnished by the physician providing renal care or by another physician. (These services may not be incidental to services furnished during a dialysis session or office visit necessitated by the renal condition.) For example, physician services rendered to hospitalized inpatient recipients who require dialysis but are not receiving dialysis on that day may use the appropriate procedure code as described in the CPT.

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Physician services are allowed for outpatient maintenance dialysis patients not performed as prescribed during a full month or interruptedly. An example of interrupted monthly outpatient dialysis maintenance is preceding and/or following the period of hospitalization.

The CPT codes described by age for physicians rendering outpatient dialysis services that are interrupted during a full month should be billed on a per day basis. These codes should be billed for the days of the month in which the outpatient ESRD related services were performed.

Single or repeated physician assessments are allowed for hemodialysis or dialysis procedures other than hemodialysis. These services are comprehensive and include assessment and management related to the patient's renal dialysis. Please utilize the most descriptive and appropriate CPT dialysis procedure when billing for single or repeated physician evaluation(s).

Dialysis training is a covered service when billed by an approved ESRD facility.

Refer to Chapter 35, Renal Dialysis Facility, for further details.

Parenteral Nutrition

The Alabama Medicaid Agency may reimburse for total parenteral nutritional (TPN) solutions through the pharmacy program if the recipient meets certain requirements as listed below. TPN solutions include those used for hyperalimentation, intradialytic parenteral nutrition (IDPN), and intraperitoneal nutrition (IPN). Requirements must be met and clearly documented in the medical record for coverage of all TPN. All services rendered are subject to post payment review.

Statement of Medical Necessity

The ordering physician will be responsible for writing a statement of medical necessity. This statement shall certify that the patient cannot be maintained on oral or enteral feedings and that due to severe pathology of the alimentary tract either hyperalimentation or IDPN/IPN must be given for 100% of nutritional needs. The original signed statement of medical necessity must be kept in the patient's medical record. This certification statement must be written or stamped on the prescription or reproduced on a form accompanying the prescription. The statement must be signed and dated by the certifying physician at the time of the initial order and updated yearly in accordance with Medicaid billing practice.

Hyperalimentation

Medicaid covers hyperalimentation for recipients who meet certain requirements of medical necessity and documentation in the medical record is sufficient based on the following:

- Documentation in the medical record must validate the patient suffers from a permanently impaired gastrointestinal tract and that there is insufficient absorption of nutrients to maintain adequate strength and weight. The following are considered conditions which could cause insufficient absorption:

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1. Crohn's disease
2. Obstruction secondary to stricture or neoplasm of the esophagus or stomach
3. Loss of ability to swallow due to central nervous system disorder, where the risk of aspiration is great
4. Short bowel syndrome secondary to massive small bowel resection
5. Malabsorption due to enterocolic, enterovesical or enterocutaneous fistulas (TPN temporary until the repair of the fistula)
6. Motility disorder (pseudo-obstruction)
7. Prolonged paralytic ileus following a major surgical procedure or multiple injuries
8. Newborn infants with catastrophic gastrointestinal anomalies such as tracheoesophageal fistulas, gastroschisis, omphalocele or massive intestinal atresia
9. Infants and young children who fail to thrive due to systemic disease or secondary to insufficiency associated with short bowel syndrome, malabsorption or chronic idiopathic diarrhea.

- Medical record documentation must include supporting evidence that the patient cannot be maintained on oral or enteral feedings and that due to severe pathology of the alimentary tract, hyperalimentation must be given in order to meet 100% of the patient's nutritional needs.
- Physical signs, symptoms and test results indicating severe pathology of the alimentary tract must be clearly documented in the medical record. This would include BUN, serum albumin, and phosphorus. Medical records must document inability to maintain weight during a trial of at least four weeks of enteral feeding.

Intradialytic Parenteral Nutrition (IDPN) and Intraperitoneal Nutrition (IPN)

IDPN and IPN involves infusing hyperalimentation fluids as part of dialysis, through the vascular shunt or intraperitoneally to normalize the amounts of albumin, glucose, and other nutrients in the blood stream to decrease morbidity and mortality associated with protein calorie malnutrition. IDPN and IPN solutions are considered **not covered** for the recipient with a functioning gastrointestinal tract whose need for parenteral nutrition is only due to the following:

- If IDPN or IPN is offered as an addition to regularly scheduled infusions of TPN
- If the recipient would not qualify as a candidate for TPN
- A swallowing disorder
- A temporary defect in gastric emptying such as a metabolic or electrolyte disorder
- A psychological disorder, such as depression, impairing food intake
- A metabolic disorder inducing anorexia, such as cancer
- A physical disorder impairing food intake, such as dyspnea or severe pulmonary or cardiac disease
- A side effect of medication

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- Renal failure and/or dialysis

The following requirements must be met in order to bill for IDPN or IPN solutions:

- Documentation in the medical record must validate the patient suffers from a permanently impaired gastrointestinal tract and that there is insufficient absorption of nutrients to maintain adequate strength and weight.
- Documentation must include that the patient cannot be maintained on oral or enteral feedings and that due to severe pathology of the alimentary tract, IDPN or IPN must be given in order to meet 100% of the patient's nutritional needs.
- Infusions must be vital to the nutritional status of the recipient and not supplemental to a deficient diet or deficiencies caused by dialysis.
- Physical signs, symptoms and test results indicating severe pathology of the alimentary tract must be clearly documented in the medical record. This would include creatinine (predialysis), serum albumin (predialysis), a low or declining serum cholesterol level, and phosphorus. Medical records must document inability to maintain weight during a trial of at least four weeks of enteral feeding.

Restrictions

A few solutions used in TPN preparation are considered payable as part of the composite rate for dialysis and should not be billed separately by the pharmacist; these are as follows:

- Glucose
- Dextrose
- Trace Elements
- Multivitamins

28.2.10 Anesthesiology

Administration of anesthesia is a covered service when administered by or directed by a duly licensed physician for a medical procedure that is covered by Medicaid. Medical direction by an anesthesiologist of more than four Certified Registered Nurse Anesthetists (CRNAs) or Anesthesiology Assistants (AAs) concurrently will not be covered.

Administration of anesthesia by an AA is a covered service when the AA has met the qualifications and standards set forth by the Alabama Board of Medical Examiners. The AA must enroll with a NPI to bill the Alabama Medicaid Program. Refer to Chapter 38, Anesthesiology, for more information.

28.2.11 Obstetrical and Related Services

The following policy refers to maternity care billed as fee-for-service. Refer to Chapter 40, for details regarding the Delivering Health Care Professionals (DHCPs) information.

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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

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"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.

NOTE:

Claims submitted by teaching facilities and board certified Perinatologist for services provided for high risk pregnancies must be billed with a TG modifier. Provider Specialty Type 922 is limited to bill three (3) office visits without the TG modifier.

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. Routine postpartum care includes a physical exam as well as family planning services to include prescribing and/or administering contraception. 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

Generally, ultrasounds are conducted to detect gestational age, multiple pregnancies, and major malformations, detect fetal growth disorders (intrauterine growth retardation, macrosomia) and anomalies. All

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ultrasounds must be medically necessary with medical diagnosis documented supporting the benefit of the ultrasound procedure.

Some medical conditions that are medically necessary are:

- Gestational diabetes with complications (Type 1 diabetes, vascular disease, hypertension, elevated alpha-fetoprotein values, poor patient compliance)
- Failure to gain weight, evaluation of fetal growth
- Pregnancy-induced hypertension
- Vaginal bleeding of undetermined etiology
- Coexisting adnexal mass
- Abnormal amniotic fluid volume (polyhydramnios, oligohydramnios)
- Pregnant trauma patient
- Congenital diaphragmatic hernia (CDH)
- Monitoring for special tests such as fetoscopy, amniocentesis, or cervical cerclage placement
- Assist in operations performed on the fetus in the uterus
- Detection of fetal abnormalities with other indicators or risk factors (Low human chorionic gonadotrophin (HCG) and high-unconjugated estriol (uE3) are predictive of an increased risk for Trisomy 18. Echogenic bowel grades 2 and 3 are indicative of an increased risk of cystic fibrosis and Trisomy 21)
- Determination of fetal presentation
- Suspected multiple gestation, serial evaluation of fetal growth in multiple gestation
- Suspected hydatidiform mole
- Suspected fetal death
- Suspected uterine abnormality
- Suspected abrupt placenta
- Follow-up evaluation of placental location for identified placenta previa

For information on diagnostic radiology procedures that require prior authorization, please refer to Chapter 22, Independent Radiology.

Emergency Services For Non-Citizens

Miscarriages

Miscarriages are not currently billable electronically. Requests concerning miscarriages for aliens who are not eligible for pregnancy or full coverage Medicaid continue to be processed manually, until further notice. Aliens, who had miscarriages, must continue to present bills timely (within three months) to the SOBRA worker, who determines eligibility; then forwards information to Central Office for manual processing. Providers will receive a check from Medicaid for miscarriages as well as other alien services approved for reimbursement.

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Delivery Services Billable Through Gainwell

For CMS-1500 (formerly HCFA-1500) medical claims, the following procedures are covered:

- 59409-vaginal delivery only
- 59612-vaginal only, after previous C-section
- 59514-c-section only
- 59620-c-section only, after attempted vaginal, after previous C-section
- 01960-vaginal anesthesia
- 01961-c-section anesthesia
- 01967-neuraxial labor analgesia/anesthesia
- 62319-epidurals

For UB-04 inpatient claims, the following per diem is covered:

- Up to 2 days for vaginal delivery
- Up to 4 days for C-section delivery.

Allowable diagnosis codes for CMS 1500 or UB-04 are:

For ICD-9

- V270-V279
- V300-V3921
- 65100-65993
- 6571-6573.

For ICD-10

- Z37.3-Z37.4
- Z37.50-Z37.54
- Z37.59
- Z37.60-Z37.64
- Z37.69
- Z37.7
- Z37.9
- Z38.00-Z38.5
- Z38.61-Z38.69
- Z38.7-Z38.8
- O09.40-O09.529
- O30.001-O36.93X9
- O40.1XX0-O43.93
- O61.0-O61.9
- O64.1XX0-O64.9XX9
- O65.0-O66.6
- O68
- O75.2-O75.3
- O75.5
- O75.89-O75.9
- O76-O77.9

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Allowable surgical codes for CMS 1500 or UB-04 are:

For ICD-9

- 740-7499.

For ICD-10

- 10A00ZZ-10A04ZZ
- 10D00Z0-10D00Z2
- 10T20ZZ-10T24ZZ

28.2.12 Vaccines For Children (VFC)

The Department of Public Health provides vaccines at no charge to Medicaid providers enrolled in the Vaccines For Children (VFC) Program as recommended by the Advisory Committee on Immunization.

Medicaid reimburses administration fees for vaccines provided free of charge through the VFC Program. The rate for the administration fee is $8.00; it is not the rate on the pricing file. Please refer to Appendix A, Well Child Check-Up, Section A.6.1 (Fees) for information regarding the use of designated VFC codes for billing immunization administration fee(s).

A VFC provider may or may not choose to become an enrolled Medicaid provider. Enrollment as a VFC provider or a Medicaid provider is independent of each other.

Refer to Appendix A, EPSDT, for procedure codes for VFC.

28.2.13 Lab Services

Collection of laboratory specimens may be billed only when sending specimens to another site for analysis if the other site is not owned, operated, or financially associated with the site in which the specimen was collected. The collection fee may not be billed if the lab work is done at the same site where the specimen was collected or in a lab owned, operated, or financially associated with the site in which the specimen was collected. Providers will not be paid for and should not submit claims for laboratory work done for them by independent laboratories or by hospital laboratories.

Providers may submit claims for laboratory work done by them in their own offices or own laboratory facilities. Providers who send specimens to independent laboratories for analysis may bill a collection fee. This fee shall not be paid to any provider who has not actually extracted the specimen from the patient.

Lab Tests Performed in Physician's Offices

When performing laboratory tests in the physician's office:

1. The Physician must be CLIA certified to perform the test,
2. The Physician must have the appropriate equipment to perform the test, and
3. The Physician's office bills for the tests performed but not the collection fee.

When specimens are sent to an outside lab:

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1. The Physician's office should not bill the laboratory code, and
2. The Physician's office may bill a collection fee with a "90" modifier for blood specimens.

EXAMPLE:

Lead Levels

Procedure Code 83655 (Lead) should only be billed when the office has the equipment to perform the test. When collecting a specimen only and then sending the blood sample to an outside lab for analysis, you must bill Procedure Code 36415 with modifier 90. The utilization of procedure code 36415-90 will enable you to receive a collection and handling fee for the specimen obtained.

Procedure code 36415-90 should not be billed when lab procedures are performed in the office. The appropriate lab procedure code(s) must be billed when actually performing the lab test. Again, the correct equipment must be utilized to perform the test. These services are subject to post-payment review. Medical record documentation must support the performance and medical necessity of the laboratory test.

NOTE:

Providers should use procedure code 36415-90 for routine venipuncture collection, 36416-90 for collection of capillary blood specimen (e.g., finger, heel, ear stick) and Q0091-90 for collection of Pap smear specimen.

Repeat Lab Procedures

Modifier 91 may be utilized to denote a repeat clinical laboratory test performed on the same date of service for the same recipient. Providers should use modifier 91 instead of modifier 76 for repeat lab procedures.

NOTE:

A physician CANNOT bill the following pathology/laboratory procedure codes; however the above collection fee can be billed, if applicable:

82775 Galactose – 1 – phosphate uridyl transferase; quantitative
83498 Hydroxyprogesterone, 17 – d
84030 Phenylalanine (PKU) blood
84437 Thyroxine; total requiring elution (e.g., neonatal)

28.2.14 Supply Code

The procedure code 99070 is utilized by physicians to bill for supplies and materials over and above those usually included with the office visit. Examples of supplies and materials over and beyond usual supplies include elastic wraps, disposable tubing for bronchial dilating equipment or post-operative dressing changes when no office visit is allowable.

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28.3 Prior Authorization and Referral Requirements

Medical care and services that require prior authorization for in-state providers will continue to require prior authorization for out-of-state providers, e.g., organ transplants and select surgical procedures. Please refer to Chapter 4, Obtaining Prior Authorization for more information.

For information regarding Prior Authorization for MRI's, CT scans, CTA's, MRA's, and PET scans, refer to chapter 22, Independent Radiology.

Unlisted services and procedure codes are not covered by the Alabama Medicaid Agency, with the exception of Medicare crossover claims and rare instances when approval is granted prior to service provision after the agency has determined that the service is covered and that no other procedure code exists for reimbursement.

NOTE:

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

28.4 Signature Requirements

Signature Requirement for Referrals: Effective May 16, 2012, for hard copy referrals, the printed, typed, or stamped name of the primary care physician with an original signature of the physician or designee is required. **Stamped or copied signatures will not be accepted.** For electronic referrals, provider certification is made via standardized electronic signature protocol.

Services that require a physician's order must be written according to practice guidelines and state/federal law and must include the date and signature of the provider, the service(s) ordered and the recipient's name. The EPSDT referral form may be considered the physician's order as long as these guidelines are met. Refer to the individual provider manual chapters for detailed description of what must be included in an order.

All entries in the medical record must be legible and complete, and must be authenticated and dated promptly by the person (identified by name and discipline) who is responsible for ordering, providing, or evaluating the service furnished. The author of each entry must be identified and must authenticate his/her entry. Authentication may include handwritten or electronic signatures, or written initials, **Stamped or copied signatures will not be accepted.**

28.5 Cost Sharing (Copayment)

The copayment amount for office visit* including crossovers is:

$3.90 for procedure codes reimbursed $50.01 and greater
$2.60 for procedure codes reimbursed between $25.01 and $50.00
$1.30 for procedure codes reimbursed between $10.01 and $25.00

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

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

If one of these CPT codes is applicable for your practice, then copay applies.

Copayment does not apply to services provided for pregnant women, nursing facility residents, recipients less than 18 years of age, emergencies, and family planning. Native American Indians that present an "active user letter" issued by Indian Health Services (IHS) will be exempt from the Medicaid required copayment.

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

28.6 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

Physicians who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When filing a claim on paper, a CMS-1500 claim form is required. Medicare-related claims must be filed using the Medical Medicaid/Medicare-related Claim Form.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

28.6.1 Time Limit for Filing Claims

Medicaid requires all claims for physicians to be filed within one year of the date of service. Refer to Section 5.1.5, Filing Limits, for more information regarding timely filing limits and exceptions.

28.6.2 Diagnosis Codes

The *International Classification of Diseases - 10th Revision - Clinical Modification* (ICD-10-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association,

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AMA Plaza 330 North Wabash Ave, Suite 39300 Chicago, IL 60611-5885, or 1-800-621-8335.

NOTE:

ICD-9 codes should be used for claims submitted with dates of service prior to or equal to 09/30/2015.

ICD-10 codes should be used for claims submitted with dates of service on or after 10/01/2015.

NOTE:

ICD-9 or ICD-10 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

28.6.3 Procedure Codes and Modifiers

Medicaid uses the Healthcare Common Procedure Coding System (HCPCS). HCPCS is composed of the following:

- American Medical Association's Current Procedural Terminology (CPT)
- Nationally assigned codes developed for Medicare
- Locally assigned codes issued by Medicaid. Effective for dates of service on or after 01/01/2004, use national codes.

Filing Claims with Modifiers

Appropriate use of CPT and HCPCS modifiers is required to differentiate between sites and procedures. It is necessary to append the appropriate anatomical modifiers to surgical codes to differentiate between multiple surgeries and sites.

Appropriate Use of Modifiers

Please refer to this CMS link for more information regarding NCCI edits: https://www.medicaid.gov/medicaid/program-integrity/national-correct-coding-initiative-medicaid/index.html

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Modifier 24 (Unrelated Evaluation and Management Service by the Same Physician During a Postoperative Period)

The Physician may need to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) unrelated to the original procedure. This circumstance may be reported by adding modifier 24 to the appropriate level of E&M service. From a coding perspective, modifier 24 is appropriate when a physician provides a surgical service related to one problem and, during the postoperative period or follow-up care for the surgery, provides and E&M service unrelated to the problem requiring the surgery.

Modifier 25 (Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service)

It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E&M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E&M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E&M service to be reported.

Modifiers 59, XE, XP, XS, and XU (Distinct Procedural Services)

Under certain circumstances, the physician may need to indicate that a procedure or service was distinct or independent from other non-E&M services performed on the same day. Modifiers 59, XE, XP, XS, and XU are used to identify procedures/services, other than E&M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injuries in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same physician. However, when another already established modifier is appropriate, it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used.

Modifiers XE, XP, XS, and XU are effective for dates of service beginning January 1, 2015 and thereafter. These modifiers were developed to provide greater reporting specificity in situations where modifier 59 was previously reported and may be utilized in lieu of modifier 59 whenever possible. (Modifier 59 should only be utilized if no other more specific modifier is appropriate.) The modifiers are defined as follows:

- **XE – Separate encounter**: A service that is distinct because it occurred during a separate encounter.

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- **XP – Separate practitioner**: A service that is distinct because it was performed by a different practitioner.

- **XS – Separate structure**: A service that is distinct because it was performed on a separate organ/structure.

- **XU – Unusual non-overlapping service**: The use of a service that is distinct because it does not overlap usual components of the main service.

Modifier 76 (Repeat Procedure by Same Physician)

The physician may need to indicate that a procedure or service was repeated subsequent to the original procedure or service. This circumstance may be reported by adding the modifier 76 to the repeated procedure/service. From a coding perspective, modifier 76 is intended to describe the same procedure or service repeated, rather than the same procedure being performed at multiple sites.

Modifier 78 (Return to the Operating Room for a Related Procedure During the Postoperative Period)

It may be necessary to indicate that another procedure was performed during the postoperative period of the initial procedure. When the subsequent procedure is related to the first, and requires the use of the operating room, it may be reported by adding the modifier 78 to the related procedure. Modifier 78 is not used for procedures that indicate in the code descriptor “subsequent, related or redo.”

Modifiers 80, 81, 82 and AS (Assistant-at-Surgery Modifiers)

An assistant-at-surgery serves as an additional pair hands for the operating surgeon. Assistants-at-surgery do not carry primary responsibility for or “perform distinct parts” of the surgical procedure. Assistant-at-surgery coverage is limited to fully qualified physicians and non-physician practitioner (i.e., PAs, CRNP, etc.) if it is within the scope of their licenses.

- **Modifier 80** – Assistant surgeon

- **Modifier 81** – Minimum assistant surgeon

- **Modifier 82** – Assistant surgeon (when qualified resident surgeon not available)

- **Modifier AS** – Physician assistant, nurse practitioner, or clinical nurse specialist for assistant at surgery.

Modifier Q5 (Service Performed by a Substitute Physician under a Reciprocal Billing Agreement)

Under certain circumstances, the physician may need to indicate that a service was provided by a substitute physician. Modifier Q5 is reported when the regular physician arranges for a substitute physician to furnish

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services on an occasional reciprocal basis. Modifier Q5 should be appended after the procedure code to indicate that the service was provided by a substitute physician under a reciprocal arrangement. When appending modifier Q5, the regular provider is certifying that the services are covered services furnished by the substitute physician. The regular physician should keep a record on file of each service provided by the substitute physician and make this record available to Medicaid upon request.

Modifier Q6 (Service Furnished by a Locum Tenens Physician)

Under certain circumstances, the physician may need to indicate that a service was provided by a locum tenens physician. A locum tenens physician generally has no practice of his/her own; he/she usually moves from area to area as needed. The regular physician generally pays the substitute physician a fixed per diem amount or other fee-for-time compensation, with the locum tenens physician having a status of an independent contractor rather than of an employee. Modifier Q6 should be appended after the procedure code to indicate that the service was provided by a locum tenens physician. The regular physician should keep a record on file of each service provided by the locum tenens physician and make this record available to Medicaid upon request.

Bilateral Procedures

Effective for dates of adjudication October 1, 2006 and thereafter the procedure for billing bilateral procedures changed. In the past, (through September 30, 2006), providers were instructed to bill for bilateral procedures on one line with modifier 50. The reimbursement was adjusted to 150% of Medicaid's fee schedule.

Effective for dates of adjudication October 1, 2006 and thereafter, the new procedure is as follows:

- Bill the appropriate procedure code on 2 separate lines with RT and LT modifier, or other appropriate anatomical modifier,
- Modifier 50 will be used for informational purposes only and is no longer a pricing modifier.
- The payment will be 100% of Medicaid fee schedule for first line and 50% for second line.
- Claims will be subject to multiple surgery payment adjustments for multiple procedures.

Example:

Line 1: 27558 RT
27558 LT; 50 (Optional use of modifier 50)

Alabama Medicaid's Fiscal Agent utilizes Optum Insight Tool to determine whether a 50 modifier or RT and LT modifier should be allowed with the procedure code billed. When an inappropriate procedure code is billed with modifier 50 or RT and/or LT modifier, the claim will deny.

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NOTE:
When Medicaid payment occurs for a procedure code billed inappropriately with modifier 50, AND/OR RT (right) AND/OR LT (left), the claim will be subject to a system adjustment in payment, post payment review, and recoupment.

Procedure Codes

The CPT manual lists most procedure codes required by Medicaid. This manual may be obtained by contacting the Order Department, American Medical Association, 515 North State Street, Chicago, IL 60610-9986. The (837) Professional electronic claim and the paper claim have been modified to accept up to four Procedure Code Modifiers.

NOTE:
Unlisted procedure codes are not covered by the Agency unless the provider requested and received approval for a prior authorization before the service is rendered. The Agency will deny all requests for payment of unlisted codes after the fact.

Physician-Employed Physician Assistants (PA) and Certified Registered Nurse Practitioners (CRNP)

CRNP and PA payment will be made only for CPT codes identified in Chapter 21, physician administered drugs, and laboratory services, (must be CLIA certified). EPSDT screenings will be covered only if the provider is enrolled in that program. Refer to Appendix A, EPSDT, for EPSDT program requirements.

The Physician's Assistant or CRNP can make physician required inpatient visits to nursing facilities. However, physician required inpatient visits to hospitals or other institutional settings cannot be made by a PA or CRNP. CRNP and PA services have been expanded. Please refer to Chapter 21 for additional information.

Global Surgical Packages

Effective for dates of adjudication 10/1/06 and thereafter, Medicaid will adopt Medicare’s RVU file designation for global surgical days. In the past and through date of adjudication September 30, 2006, Medicaid has used a 62 day post op period after major surgeries.

Effective for dates of adjudication 10/1/06 and thereafter, Medicaid will use a zero, 10 day, and 90 day post op period for routine surgical care. Routine post-surgical care in the hospital or office setting for conditions directly related to surgical procedures is covered by the surgical fee. Depending on post-operative period, post-surgical visits cannot be billed separately the day of, or up to 90 days after surgery.

For conditions unrelated to the surgical procedure bill the appropriate (E&M) procedure code with a 24 modifier appended. The diagnosis must support use of the modifier 24.

Claims for these services will be subject to post payment review.

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Refer to this Medicare RVU file:http://www.cms.gov/apps/physician-fee-schedule/overview.aspx for global surgical procedure codes Zero, 10 and 90 day(s) post-operative period.

Professional and Technical Components

Some procedure codes in the 70000, 80000, 90000, and G series are a combination of a professional component and a technical component. Therefore, these codes may be billed one of three different ways; (1) as a global, (2) as a professional component, or (3) as a technical component. NOTE: Not all providers are allowed to bill any or all of the three ways to bill. Specific coverage questions should be addressed to the Provider Assistance Center.

- **Global**, the provider must own the equipment, pay the technician, review the results, and provide a written report of the findings. The procedure code is billed with no modifiers. The Global component should be billed only for the following place of service locations:
  - 11 (Office)
  - 81 (Independent Laboratory)

- **Professional component**, the provider does not own or operate the equipment. The provider reviews the results, and provides a written report of the findings. The Radiological professional component is billed by adding modifier 26 to the procedure code, and should be billed only for the following place of service locations:
  - 21 (inpatient hospital)
  - 22 (outpatient hospital)
  - 23 (emergency room - hospital)
  - 51 (inpatient psychiatric facility)
  - 61 (comprehensive inpatient rehab facility)
  - 62 (comprehensive outpatient rehab facility)
  - 65 (end-stage renal disease facility)
  - 81 (Independent Laboratory)

- **Technical component**, the provider must own the equipment, but does not review and document the results. The technical component charges are the facility's charges and are not billed separately by physicians. The technical component is billed by adding modifier TC to the procedure code. The technical component can only be billed by facilities.

28.6.4 Billing for ACHN Referred Service

Please refer to Chapter 40 for information regarding the ACHN Program.

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28.6.5 Place of Service Codes

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

POS	Description
02	Telemedicine Services
11	Office
12	Home
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room - Hospital
24	Ambulatory Surgical Center
25	Birthing Center
26	Military Treatment Facility
31	Skilled Nursing Facility or Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
34	Hospice
41	Ambulance - Land
42	Ambulance - Air or water
51	Inpatient Psychiatric Facility
52	Psy. Fac. Partial Hospitalization
53	Community Mental Health Center
54	Intermediate Care Fac./ Individuals with Intellectual Disabilities
55	Residential Substance Abuse Treatment Facility
56	Psychiatric Residential Treatment Center
61	Comprehensive Inpatient Rehabilitation Facility
62	Comprehensive Outpatient Rehabilitation Facility
65	End Stage Renal Disease Treatment Facility
71	State or Local Public Health Clinic
72	Rural Health Clinic

28.6.6 Required Attachments

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

- Claims With Third Party Denials

NOTE:

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

Refer to Section 5.8, Required Attachments, for more information on attachments.

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28.6.7 Consent Forms Required Before Payments Can Be Made

NOTE:

Gainwell will NOT pay any claims to ANY provider until a correctly completed original of the appropriate form is on file at Gainwell. Please note, **only the surgeon** should submit consent forms to Gainwell. All other providers should not request and or submit copies of the consent form. Multiple copies slow down the consent form review and claims payment process.

Abortions

In accordance with federal law, abortions are covered only (1) if the pregnancy is the result of an act of rape or incest; or (2) where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.

On July 1, 2016, Alabama Medicaid implemented fillable Portable Document Format (PDF) versions of the Abortion Consent forms that enable faster processing of provider submitted information. Providers **must** use these fillable consent forms with the digital submission of Consent Forms and supporting documentation. Any form received that is not in a fillable format will be returned to the provider.

Effective October 26, 2016, providers will be able to upload or fax their fillable Consent Forms (Abortion) and supporting documentation for review and processing via the Forms menu of the Alabama Medicaid Interactive Web Portal. A new form will allow providers the ability to upload Consent Forms and supporting documents in PDF format or create a fax barcode cover sheet from the Web Portal. Providers may submit additional documentation via fax at a later time and have that documentation combined with original document through the use of the same barcode cover sheet.

Providers must submit the completed form and supporting documentation via Provider Web Portal upload or fax to Gainwell at: (334) 215-7416.

NOTE:

Abortion Consent forms and supporting documentation will be accepted in paper format via mail or fax until November 26, 2016. After that date, consent forms and supporting documentation submitted to Gainwell on paper will be returned to the provider.

Please refer to Chapter 5, Filing Claims, for instructions on using the digital submission of Consent Forms and supporting documentation.

In the case of abortions performed secondary to pregnancies resulting from rape or incest, the documentation required is a letter from the recipient or provider certifying that the pregnancy resulted from rape or incest.

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- A second copy of the consent form or certification letter must be placed in the recipient's medical record.

All claims relating to abortions must have the above-specified documentation on file at Gainwell prior to payment.

This documentation is not required when a recipient presents with a spontaneous abortion.

If the recipient does not qualify for payment by Medicaid and elects to have the abortion, providers may bill the recipient for the abortion as a non-covered service.

The fillable consent forms are available under the Resource tab on the Alabama Medicaid website at: www.medicaid.alabama.gov.

Sterilization

Gainwell must have on file the Medicaid-approved sterilization form. Refer to Appendix C, Family Planning, for more information. See Appendix E, Medicaid Forms for a copy of this form, or visit the Medicaid website at: www.medicaid.alabama.gov. for an electronic fillable version of this form.

Effective October 27, 2016, providers will be able to upload or fax their fillable Consent Forms (Sterilization) and supporting documentation for review and processing via the Forms menu of the Alabama Medicaid Interactive Web Portal. A new form will allow providers the ability to upload Consent Forms and supporting documents in PDF format or create a fax barcode cover sheet from the Web Portal. Providers may submit additional documentation via fax at a later time and have that documentation combined with original document through the use of the same barcode cover sheet. The provider must submit a copy of the recipient's signed sterilization consent form to Gainwell via Provider Web Portal upload or fax. Fax form and supporting documentation to Gainwell at: (334) 215-7416.

Refer to Appendix C for detailed instructions.

Sterilization by Hysterectomy

Payment is not available for a hysterectomy if:

1. **It was performed solely for the purpose of rendering an individual permanently incapable of reproducing**
2. **If there was more than one purpose to the procedure, it would not have been performed but for the purpose of rendering the individual permanently incapable of reproducing**

NOTE:

Sterilization performed for the sole purpose of rendering a person permanently incapable of reproducing is not available to persons under twenty-one (21) years of age under the Medicaid Program.

Refer to Appendix E, Medicaid Forms, for a sample of the sterilization form.

Hysterectomy

Hysterectomy procedures performed for the sole purpose of rendering an individual incapable of reproducing are not covered under Medicaid.

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Hysterectomies done as a medical necessity as treatment of disease can be paid for by the Medicaid funds under the physician's program.

The hysterectomy consent form was revised to include a section for unusual circumstances. This form should be used by a physician to certify a patient was already sterile when the hysterectomy was performed; a hysterectomy was performed under a life threatening situation; or a hysterectomy was performed under a period of retroactive Medicaid eligibility. In all of these circumstances, medical records must be sent to Gainwell through digital submission along with the hysterectomy consent form and claim(s) in order for a State review to be performed.

NOTE:

The **doctor's explanation** to the patient that the operation will make her sterile and the **doctor's and recipient's signature** must precede the operation except in the case of medical emergency. If a field is missing, contains invalid information or indicates the recipient/representative or physician signed after the date of surgery, Gainwell will return the consent form to the provider to correct invalid information.

Gainwell must have on file a Medicaid-approved Hysterectomy Consent Form.

On July 1, 2016, Alabama Medicaid implemented fillable Portable Document Format (PDF) versions of the Hysterectomy Consent form that enables faster processing of provider submitted information. Providers **must** use the fillable consent form with the digital submission of Consent Forms and supporting documentation. Any form received that is not in a fillable format will be returned to the provider.

Effective October 26, 2016, providers will be able to upload or fax their fillable Consent Forms (Abortion, Hysterectomy) and supporting documentation for review and processing via the Forms menu of the Alabama Medicaid Interactive Web Portal. A new form will allow providers the ability to upload Consent Forms and supporting documents in PDF format or create a fax barcode cover sheet from the Web Portal. Providers may submit additional documentation via fax at a later time and have that documentation combined with original document through the use of the same barcode cover sheet.

The fillable consent forms are available under the Resource Tab on the Alabama Medicaid website in the section labeled Consent Forms at: www.medicaid.alabama.gov.

Providers must submit the completed form and supporting documentation via Provider Web Portal upload or fax to Gainwell at: (334) 215-7416.

NOTE:

Hysterectomy Consent forms and supporting documentation will be accepted in paper format via mail or fax until November 26, 2016. After that date, consent forms and supporting documentation submitted to Gainwell on paper will be returned to the provider.

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Please refer to Chapter 5, Filing Claims, for instructions on using the digital submission of Consent Forms and supporting documentation.

Exceptions That Do Not Require Prior Completion of the Consent Form

In the following situations, the consent form is required and section III and IV of the consent form must be completed.

1. The physician who performed the hysterectomy certifies in writing that the patient was already sterile when the hysterectomy was performed; the cause of sterility must be stated in this written statement. Refer to Section IV on the consent form.
2. The physician who performed the hysterectomy certifies in writing that the hysterectomy was performed under a life-threatening emergency situation in which prior acknowledgement was not possible. This written statement must include a description of the nature of the emergency. Refer to Section IV on the consent form.
3. The hysterectomy was performed during a period of retroactive Medicaid eligibility, and the physician who performed the hysterectomy submits, in lieu of the consent form, a written statement certifying that the individual was informed before the operation that the hysterectomy would make her sterile. Refer to Section IV on the consent form.

NOTE:

Medicaid payment cannot be made for any claims for services provided in connection with an abortion, a sterilization procedure or a hysterectomy for medical reasons unless an approved consent form is on file. Please be aware consent for sterilization is different from consent for hysterectomy. See Appendix E, Medicaid Forms, for examples of each.

28.7 For More Information

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

Resource	Where to Find It
CMS-1500 Claim Filing Instructions	Chapter 5
Medical Medicaid/Medicare-related Claim Filing Instructions	Chapter 5
Medical Necessity/Medically Necessary Care	Chapter 7
Anesthesiology	Chapter 38
EPSDT	Appendix A
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
Family Planning	Appendix C
Alabama Medicaid Injectable Drug List	Medicaid website
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N
CRNP and PA Services	Chapter 21

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29

29 Podiatrist

Podiatrists are enrolled only for services provided to QMB recipients or to recipients referred as a result of an EPSDT screening.

The policy provisions for podiatrists can be found in the *Alabama Medicaid Agency Administrative Code*, Chapter 11.

29.1 Enrollment

Alabama Medicaid's Fiscal Agent enrolls podiatrists and issues provider contracts to applicants who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code*, and the *Alabama Medicaid Provider Manual*.

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

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

National Provider Identifier, Type, and Specialty

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

NOTE:
The 10-digit NPI is required when filing a claim.

Podiatrists are assigned a provider type of 14 (Podiatrist). Valid specialties for podiatrists include the following:

- Podiatry (140)
- QMB/EPSDT (600)

Enrollment Policy for Podiatrists

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

- Possess a current license issued to practice podiatry

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- 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. Refer to Chapter 7, Understanding Your Rights and Responsibilities as a Provider, for general criteria on Medical Necessity/ Medically Necessary Care.

Podiatry services are covered only for services provided to QMB recipients or to recipients referred as a result of an EPSDT screening.

For more information regarding the EPSDT program, refer to Appendix A, EPSDT.

29.3 Prior Authorization and Referral Requirements

Podiatrists may provide services for QMB recipients or to recipients referred as a result of an EPSDT screening.

For podiatry services to be paid by Medicaid for non-QMB recipients (i.e., EPSDT), the service must be medically necessary and the result of a referral from a contracted Medicaid EPSDT screening provider. Screening providers will complete and forward an Agency Referral Form (form 362), which must identify the reason for referral and serve as documentation that the services provided were the result of an EPSDT screening.

Signature Requirement for Referrals: Effective May 16, 2012:
For hard copy referrals, the printed, typed, or stamped name of the primary care physician with an original signature of the physician or designee is required. **Stamped or copied signatures will not be accepted**. For electronic referrals, provider certification is made via standardized electronic signature protocol.

When filing claims for recipients enrolled in the Alabama Coordinated Health Network (ACHN) Program, refer to Chapter 40 to determine whether your services require a referral from the Primary Care Physician (PCP).

29.4 Cost Sharing (Copayment)

The copayment amount for office visit* including crossovers is:

$3.90 for procedure codes reimbursed $50.01 and greater
$2.60 for procedure codes reimbursed between $25.01 and $50.00
$1.30 for procedure codes reimbursed between $10.01 and $25.00

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

99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245,
If one of these CPT codes is applicable for your practice, then copay applies.

Copayment does not apply to services provided for pregnant women, nursing facility residents, recipients less than 18 years of age, emergencies, and

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family planning. Native American Indians that present an "active user letter" issued by Indian Health Services (IHS) will be exempt from the Medicaid required copayment.

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

29.5 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

Podiatrists who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When filing a claim on paper, a CMS-1500 claim form is required. Medicare-related claims must be filed using the Medical Medicaid/Medicare-related Claim Form.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

29.5.1 Time Limit for Filing Claims

Medicaid requires all claims for podiatrists to be filed within one year of the date of service. Refer to Section 5.1.4, Filing Limits, for more information regarding timely filing limits and exceptions.

29.5.2 Diagnosis Codes

The *International Classification of Diseases - 10th Revision - Clinical Modification* (ICD-10-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, AMA Plaza 330 North Wabash Ave, Suite 39300 Chicago, IL 60611-5885, or 1-800-621-8335.

NOTE:

ICD-10 codes should be used for claims submitted with dates of service on/after 10/01/2015.

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NOTE:

ICD-9 or ICD-10 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

29.5.3 Procedure Codes and Modifiers

Podiatry providers use the Current Procedural Terminology (CPT) coding system. The CPT manual lists most required procedure codes. This manual may be obtained by contacting the Order Department, American Medical Association, 515 North State Street, Chicago, IL 60610-9986.

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

Podiatry CPT codes describing procedures performed on the foot and toes range from 28001 - 29909. In addition to the 28001-29909 CPT codes, podiatrists may also use the evaluation and management codes 99202-99215 and nail codes 11719-11765. Procedure code coverage, maximum units and prior authorization requirements should be checked through AVRS prior to rendering service. Refer to Appendix L, AVRS Quick Reference Guide, for more details on verifying this information.

29.5.4 Place of Service Codes

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

POS Code	*Description*
11	Office
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room – Hospital
24	Ambulatory Surgical Center
31	Skilled Nursing Facility or Nursing Home
32	Nursing Facility
51	Inpatient Psychiatric Facility
52	Psychiatric Facility Partial Hospitalization
54	Intermediate Care Facility/Mentally Retarded
61	Comprehensive Inpatient Rehabilitation Facility
62	Comprehensive Outpatient Rehabilitation Facility
71	State or Local Public Health Clinic
72	Rural Health Clinic

29.5.5 Required Attachments

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

- Claims With Third Party Denials

NOTE:

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

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Refer to Section 5.8, Required Attachments, for more information on attachments.

29.6 For More Information

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

Resource	Where to Find It
CMS-1500 Claim Filing Instructions	Chapter 5
Medical Medicaid/Medicare-related Claim Filing Instructions	Chapter 5
Medical Necessity/Medically Necessary Care	Chapter 7
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

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

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

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

National Provider Identifier, Type, and Specialty

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

NOTE:

The 10-digit NPI is required when filing a claim.

Preventive health education providers are assigned a provider type of 55 (Private Prenatal Education). The valid specialty for preventive health education providers is Preventive Health Education (183).

Enrollment Policy for Preventive Health Education Providers

Providers include clinics or other organizations that use licensed practitioners of the healing arts within the scope of practice under state law and federal regulations.

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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.

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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. Refer to Chapter 7, Understanding Your Rights and Responsibilities as a Provider, for general criteria on Medical Necessity/ Medically Necessary Care.

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.

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When filing claims for recipients enrolled in the Alabama Coordinated Health Network (ACHN) Program, refer to Chapter 40, ACHN, to determine whether your services require a referral from the Primary Care Provider (PCP).

30.4 Cost Sharing (Copayment)

Copayment does not apply to services provided by preventive health education providers.

30.5 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

Preventive health education providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:
When filing a claim on paper, a CMS-1500 claim form is required.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

30.5.1 Time Limit for Filing Claims

Medicaid requires all claims for preventive health education to be filed within one year of the date of service. Refer to Section 5.1.5, Filing Limits, for more information regarding timely filing limits and exceptions.

30.5.2 Diagnosis Codes

The *International Classification of Diseases - 10th Revision - Clinical Modification* (ICD-10-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, AMA Plaza 330 North Wabash Ave, Suite 39300 Chicago, IL 60611-5885, or 1-800-621-8335.

Prenatal Education services are limited to diagnosis code V220 - V222 for ICD-9 or Z34.00, Z34.80, and Z33.1 for ICD-10. Adolescent Pregnancy Prevention Education services are limited to diagnosis code V2509.

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NOTE:

ICD-9 codes should be used for claims submitted with dates of service prior to or equal to 09/30/2015.

ICD-10 codes should be used for claims submitted with dates of service on/after 10/01/2015.

30.5.3 Procedure Codes and Modifiers

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

Services are **limited** to the billing of the following two procedure codes:

Procedure Code	*Description*
S9445	Prenatal Education – Limited to pregnant female recipients. Limited to diagnosis code V220 - V222 for ICD-9 or Z34.00, Z34.80, and Z33.1 for ICD-10.
99412	Adolescent Pregnancy Prevention Education – Limited to recipients ages 10-20. Limited to diagnosis code V2509 for ICD-9 and Z30.09 for ICD-10.

30.5.4 Place of Service Codes

The following place of service code applies when filing claims for preventive health education services:

Code	*Description*
99	Other Unlisted Facility

30.5.5 Required Attachments

NOTE:

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

Refer to Section 5.8, Required Attachments, for more information on attachments.

30.6 For More Information

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

Resource	Where to Find It
CMS-1500 Claim Filing Instructions	Chapter 5
Medical Necessity/Medically Necessary Care	Chapter 7
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31 Private Duty Nursing

The purpose of the Private Duty Nursing Program is to provide payment for quality, safe, cost-efficient skilled nursing care to Medicaid recipients who require a minimum of four consecutive hours of continuous skilled nursing care per day. Skilled nursing care is defined as prescribed care that can only be provided by a licensed Registered Nurse (RN) or Licensed Practical Nurse (LPN) which is medically necessary to treat or ameliorate medical conditions identified as a result of an EPSDT screening. The medical criteria herein must be present when the specified condition listed below is found. For conditions not found in the Alabama Medicaid Administrative Code, medical necessity review will be conducted by the Medicaid Medical Director. Medicaid recipients who do not meet the medical necessity requirements for the Private Duty Nursing Program have access to a variety of nursing and related community services. The Agency will make referrals to the appropriate programs based on the level of care needed.

A private duty-nursing agency is a public agency, voluntary non-profit organization, or proprietary agency that provides a minimum of four hours per day of continuous skilled nursing care in the recipient's home. Recipients eligible for in-home private duty-nursing services may be considered for services when normal life activities take the recipient outside the home.

NOTE:

Providers of private duty nursing services under the Technology Assisted (TA) Waiver for Adults should refer to the Alabama Medicaid Provider Manual, Chapter 107 for policy provisions.

The policy provisions for private duty-nursing can be found in the *Alabama Medicaid Agency Administrative Code,* Chapter 11.

31.1 Enrollment

Gainwell enrolls 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*.

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

National Provider Identifier, Type, and Specialty

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

NOTE:
The 10-digit NPI is required when filing a claim.

Private duty nursing providers are assigned a provider type of *52* (Private duty nursing). The valid specialty is Private duty nursing (580).

Enrollment Policy for Nursing Providers

Private duty-nursing providers enroll as EPSDT only. Only in-state private duty-nursing providers and out-of-state providers within 30 miles of the state line qualify for participation in the Medicaid program. Private duty-nursing providers must have a RN on staff.

1. All employees' files should contain updated information that will include, at a minimum, full name, job title indicating full or part time status, address, phone numbers, emergency contacts, current state board RN license or LPN license, current TB skin test, background check information and current daily work schedules. The statewide background check shall consist of the following personal identifiers: name, social security number, date of birth, and driver's license number and/or applicable state identification card (i.e. non-drivers identification).
2. The authorized background check agency shall notify the potential employed if the background check reveals that an applicant is listed in the national sex offender public registry. Applicants must not have convictions or pending charges for any crime of violence or any felony conviction as well as any pending felony arrests.
3. If a Private duty Nursing (PDN) provider operates from a home office, a specified room for office space for the business must be separated from the personal dwelling in the home. Office space with locked file cabinets for business and confidential files for Protected Health Information is required. All medical records must be retained for audit purposes. A sitting area must be included in the office space to meet with employees, recipients, or business associates.

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

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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. Refer to Chapter 7, Understanding Your Rights and Responsibilities as a Provider, for general criteria on Medical Necessity/ Medically Necessary Care.

Nursing services must be prescribed as medically necessary by a licensed physician as a result of an EPSDT screening referral, based on the expectation that the recipient's medical needs are adequately and safely met in the home.

The EPSDT screening is valid for up to one year. If the need for services continues beyond the valid date, a new EPSDT screening is required.

All private duty-nursing services require prior authorization. Additionally, the recipient must be under 21 years of age to qualify and must be Medicaid eligible.

The recipient must require skilled nursing care which exceeds the caregiver's ability to care for the recipient without the assistance of at least four consecutive hours of skilled nursing care.

Qualified Caregiver

Major commitment on the part of the recipient's family is mandatory to meet the recipient's needs. The primary caregiver must sign the *Private Duty Nursing Agreement for Care* form agreeing to participate in and complete training. Additional caregivers identified for training must be indicated on the *Private Duty Nursing Agreement for Care* form (Form 388). In the event that multiple caregivers exist, an adjustment in the hours approved for PDN will occur.

- The family must have at least one member capable of and willing to be trained to assist in the provision of care for the recipient in the home.
- The family must provide evidence of parental or family involvement, and an appropriate home situation (for example, a physical environment and geographic location for the recipient's medical safety).
- Reasonable plans for emergencies (such as power and equipment backup for those with life-support devices) and transportation must be established.

Hours Allowed For Continuation of Private Duty Nursing Services Under the Following Circumstances:

- Temporary Illness: Private duty nursing hours may be provided for a period up to 90 days if the primary caregiver is incapacitated due to personal illness or illness of another family member who is dependent upon the caregiver and there is no other trained caregiver available in the home. Temporary illness includes a required surgical procedure due to illness/disease, an illness which would be a danger to the child because of contagion, or an illness which is debilitating for a limited period. Medical documentation from the caregiver's attending physician is required. The number of hours approved is dependent upon the specific circumstances.

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- Patient at Risk: Private duty nursing hours may be approved if the patient appears to be at risk of abuse, neglect, or exploitation in the domestic setting and a referral for investigation has been made to the appropriate state agency. The number of hours approved is dependent upon the specific circumstances.
- Sleep: Private duty nursing hours may be provided up to eight hours depending on the situation of the primary care giver. For example, a single parent with no other family support may be granted a full eight hours while two parents serving as primary caregivers may require fewer hours or only hours on an occasional basis.
- Work: Private duty nursing hours provided will be up to the number of hours that the primary caregiver is at work plus one hour travel time. If additional travel time is needed beyond one hour, documentation must be provided to justify the increase. *A Private Duty Nursing Verification of Employment/School Attendance* form (Form 387) providing documentation of work hours must be completed.
- School: Private duty nursing hours provided will be up to the number of hours that the primary caregiver is attending class plus one hour travel time. If additional travel time is needed beyond one hour, documentation must be provided to justify the increase. A current course selection guide published by the school, validated class schedule from school, curriculum guide and transcripts of previous courses taken must be provided along with a completed *Private Duty Nursing Verification of Employment/School Attendance form (Form 387)*. The coursework must be consistent with the requirement for obtaining a GED, college degree, or some other type of certification for employment. Courses selected must follow a logical approach with class hours being taken one after the other unless the course has been indicated by school officials as “closed”.

NOTE:

The private duty-nursing program does not cover recipients receiving skilled nursing care through the home health program. Nursing care covered by Medicaid in both programs would result in duplicate reimbursements.

NOTE:

Any private duty nursing hours approved will be reduced by the number of hours of care which are provided or are available from other resources. Hours provided by sources other than Medicaid must be reported on the Private Duty Nursing Agreement for Care form (Form 388). In the event a child eligible for Medicaid is already attending or plans to attend public school, the case manager should

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contact the Special Education Coordinator within the appropriate school district to request that the child's Individual Education Program (IEP) committee meet to determine the student's need for related services. The names and contact information for the coordinators are on the education website at www.alsde.edu. The Individuals with Disabilities Education Act (IDEA) guarantees every child the right to a free, appropriate public education and related services in the least restrictive environment. The case manager may be asked to be part of the client's IEP team to facilitate the coordination of necessary related services. Related services needed in the school that are the same as services provided in the home should be closely coordinated. For example, a child needing nursing services should be evaluated and recommended for the appropriate level of care to ensure no break in services if services previously provided by Medicaid are subsequently provided by the school district. For children attending public school, the number of approved hours may be modified during the summer months and school breaks.

NOTE:

When a Private Duty Nursing (PDN) applicant is added to the PDN Program, they may be granted more PDN hours beyond what is normally approved. The purpose of the additional hours initially is to give the PDN provider time to train the qualified caregiver(s). However during the recertification period, the PDN hours may be decreased to the hours determined by the PDN criteria.

31.2.1 Criteria for Non-Ventilator-Dependent Recipients

High technology non-ventilator-dependent recipients may qualify for private duty-nursing services if they meet either of the following criteria and at least one qualified caregiver has been identified:

- Any one of the primary requisites is present.
- Two or more secondary requisites are present.

Primary Requisites

Primary requisites include, but may not be limited to, the following as qualifying criteria for nursing recipients:

- Tracheotomy –Coverage for a functioning tracheotomy requiring oxygen supplementation; and nebulizer treatments or cough assist/inexsufflator devices. Continuation of nursing services may be approved after initial certification for those periods of time when the qualified primary caregiver is away from the home for work or school or otherwise unable to provide the necessary care.
- Total Parenteral Nutrition (TPN) - Coverage up to two months for acute phase with additional certification based upon the need for continuing therapy
- Intravenous Therapy - Coverage up to two months for a single episode. The number of hours required for a single infusion must be at least four continuous hours and require monitoring and treatment by a skilled nurse. An additional period of certification may be approved based on medical necessity for continuing therapy. Additional hours may also be

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approved for secondary criteria requisites listed below in conjunction with the primary criteria requisites.

Secondary Requisites

Secondary requisites include, but may not be limited to the following as qualifying criteria for nursing recipients:

- Decubitus ulcers - coverage for stage three or four ulcers
- Colostomy or ileostomy care - coverage for new or problematic cases
- Suprapubic catheter care - coverage for new or problematic cases
- Internal nasogastric or gastrostomy feedings - coverage for new or problematic cases
- Tracheotomy
- A documented illness or disability, which requires ongoing skilled observation, monitoring and judgment to maintain or improve health status of a medically fragile or complex condition to include at least one (1) of the following:
    a. An unstable seizure disorder
    b. Unstable respiratory function
    c. Unstable vital signs
    d. A cardiac pacemaker
    e. Unstable shunted hydrocephalus or otherwise unstable neurological status and delayed skilled intervention is expected to result in:
        - Deterioration of a chronic condition
        - Loss of function
        - Imminent risk to health status due to medical fragility
- Extensive or complete assistance with activities of daily living in a child of an age normally expected to perform ADLs such as eating, bathing, dressing, and mobility, bowel and bladder control.

31.2.2 Criteria for Ventilator-Dependent Recipients

Ventilator dependent recipients may qualify for private duty-nursing services if any one of the primary requisites is present and at least one qualified caregiver has been identified.

Primary Requisites

Primary requisites include, but may not be limited to the following as qualifying criteria for nursing recipients:

- Mechanical ventilator support is necessary for at least six hours per day and appropriate weaning steps are in progress on a continuing basis.
- Frequent ventilator checks are necessary. Frequent ventilator checks are defined as daytime versus nighttime setting changes, weaning in progress, or parameter checks a minimum of every eight hours with subsequent ventilator setting changes.
- Oxygen supplementation for ventilator dependent recipients is at or below an inspired fraction of 40 percent (Fi02 of 0.40).

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31.2.3 Scope of Services

This section lists the scope of services provided by professional nurses and licensed practical nurses for private duty nursing.

Registered Nurse Services (RN)

A registered nurse employed by a Medicaid-enrolled private duty-nursing agency may provide continuous skilled nursing services to the recipient if a licensed physician prescribes the services and Medicaid grants prior authorization.

The RN completes an in-home assessment to determine if services may be safely and effectively administered in the home. The registered nurse establishes a nursing care plan complying with the plan of treatment.

The RN must make monthly supervisory visits to evaluate the appropriateness of services rendered by a licensed practical nurse (LPN). An RN must be on call 24 hours a day, seven days a week.

Licensed Practical Nurse Services (LPN)

The LPN may provide continuous skilled nursing services for the recipient if a licensed physician prescribes the services and Medicaid grants prior authorization. The LPN works under the supervision of the RN.

The RN evaluates the recipient and establishes the plan of care prior to assigning recipient services to the LPN.

The Medicaid program requires that the RN on a monthly basis provides direct or indirect supervisory visits of the LPN in the home of each recipient the LPN serves. Direct supervisory visits are made by the RN to observe the appropriateness of LPN services when the LPN is present. Indirect supervisory visits are made by the RN to observe the appropriateness of LPN services when the LPN is not present.

Missed Visits

(1) A missed visit occurs when the client is at home waiting for scheduled services, but the services are not delivered.

(2) The DSP shall have a written policy assuring that when a Private Duty Nurse is unavailable, the Supervisor assesses the need for services and makes arrangements for a substitute to provide services as necessary.

  (a) If the Supervisor sends a substitute, the substitute will complete and sign the service log after finishing duties.

  (b) If the Supervisor does not send a substitute, the Supervisor will contact the client and inform them of the unavailability of the Private Duty Nurse.

(3) The DSP will document missed visits in the client’s files.

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31.2.4 Documentation of Services

The private duty-nursing agency is responsible for establishing and maintaining a permanent medical record for each recipient including the following:

- Home Health Certification and Plan of Care form (HCFA-485) for certification and re-certification signed by the physician
- Medical Update and Patient Information form (HCFA-486)
- Private Duty Nursing Agreement for Care form (Form 388)
- Alabama Medicaid Agency Referral form (Form 362)
- Any additional physician orders
- Signature log with dates, duration of visits, types of service, and signature of the RN/LPN and the caregiver (a copy must be provided to the recipient or recipient's representative).
- Continuous progress reports
- Documentation of in-home RN visits to supervise the LPN

Medical records shall be retained for at least three years plus the current year.

Plan of Care for Private Duty Nursing

A plan of care must be developed and submitted with each request for service documenting the extent of nursing needs. Each professional participating in the recipient's care must carefully review the recipient's status and needs. Each discipline must formulate goals and objectives for the recipient and develop daily program components to meet these goals in the home. This plan must also include the following:

- Designation of a home care service coordinator
- Involvement of a primary care physician with specific physician orders for medications, treatments, medical follow-up, and medical tests as appropriate
- Family access to a telephone
- A plan for monitoring and adjusting the home care plan
- A defined backup system for medical emergencies
- A plan to meet the educational needs of the recipient
- A clearly shown planned reduction of private duty hours
- Criteria and procedures for transition from private duty-nursing care, when appropriate

At each certification, the care plan will be denied, approved, or returned to request additional information. The recipient should transition to the most appropriate care when the recipient no longer meets the private duty-nursing criteria. The most appropriate care may be home care services, nursing facility placement, or the Home and Community Based Waiver Program.

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31.2.5 Non-Covered Private Duty Nursing Services

When the recipient does not meet the medical need and diagnosis criteria or does not require at least four consecutive hours of continuous skilled nursing care per day, Medicaid will not cover private duty-nursing services.

Medicaid does not provide private duty-nursing services under the following circumstances:

- Observational care for behavioral, eating disorders, or for medical conditions that do not require medically necessary intervention by skilled nursing personnel
- Services not prescribed to treat or improve a condition identified as a result of an EPSDT screening
- Custodial, sitter, and respite services
- Services after the recipient is admitted to a hospital or a nursing facility
- Services after the recipient is no longer eligible for Medicaid

If the provider fails to comply with agency rules and program policies, Medicaid may recoup payments and terminate the provider contract.

Please refer to the *Alabama Medicaid Agency Administrative Code,* Chapter 11, for detailed policy information.

31.3 Prior Authorization and Referral Requirements

All private duty-nursing services require prior authorization. Refer to Chapter 4, Obtaining Prior Authorization, for general guidelines.

Private duty-nursing providers are required to submit to Gainwell the following forms for consideration of authorization for services:

- Alabama Prior Review and Authorization Request form (Form 342)
- Alabama Medicaid Agency Referral form (Form 362)
- Home Health Certification and Plan of Care form (HCFA-485) for certification and recertification signed by the physician.
- Medical update and Patient Information form (HCFA-486)
- Private Duty Nursing Agreement for Care form (Form 388)
- Any additional physician orders

When filing claims for recipients enrolled in ACHN Program, refer to Chapter40, ACHN Billing Manual to determine whether your services require a referral from the Primary Care Physician (PCP).

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The Alabama Medicaid Agency Referral form (Form 362) is valid for one year from date of screening. If the recipient continues to be approved for services beyond the one year screening date, a new Alabama Medicaid Agency Referral form (Form 362) indicating the current screening date and appropriate information must be submitted

Re-certification

Every three months, documentation consisting of the Home Health Certification and Plan of Care (Form CMS 485), the Medical Update and Patient Information (Form CMS 486), Verification of Employment /School Attendance (Form 387), Private Duty Nursing Agreement for Care form (Form 388), and two weeks of nursing record documentation must be submitted to Gainwell to support the need for continuation of private duty-nursing services. Providers must submit re-certification requests to Gainwell **at least** 14 days prior to the re-certification due date. Re-certifications not received timely will be approved when criteria are met based on date of receipt. The request for re-certification will be approved or denied based on Medicaid criteria. Gainwell denies claims for services rendered after the cancellation date.

In an emergency where the delay of adjustment of prior authorization hours would endanger the health of the recipient, the case manager, private duty-nursing agency, or parent should initiate a change request within 24 hours of the onset of the emergency by calling Kepro at (800)-426-7259 or (800)-472-2902. If the emergency situation occurs after hours, on weekends, or on a holiday, a voice message left at the same number or a fax sent to (833)-536-2134 or (833)536-2136 will be accepted for consideration. The message must include the following information:

- Recipient's name
- Recipient's Medicaid number (13 digits)
- NPI of Private Duty Nursing Agency
- Phone number of Private Duty Nursing Agency
- Phone number and name of case manager, if applicable
- Nature of emergency and number of hours involved
- Contact person and contact telephone number for follow-up

The Addendum to the Care Plan (HCFA-487) and a Medical Update and Patient Information Form (HCFA-486) must be received by Kepro within ten calendar days of the voice message/fax request. Form HCFA-486 should indicate the reason for the emergency request (example; "child is ill and did not report to school") giving the date and the number of hours involved. If the documentation is not received within ten calendar days, the authorized START DATE will be the Julian (receipt) date of approval. To be approved, the request must meet established guidelines and criteria as set forth in Chapter 31 of the Provider Manual. Initiation of the Emergency Procedures does not guarantee approval but establishes the earliest start date.

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31.4 Cost Sharing (Copayment)

Copayment does not apply to services provided by private duty-nursing providers.

31.5 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers are encouraged to bill Medicaid claims electronically.

Private duty-nursing providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When filing a claim on paper, a UB-04 claim form is required. When completing the UB-04, enter type of bill 331. Medicare-related claims must be filed using the Institutional Medicaid/Medicare Related Claim Form (Form 341).

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

31.5.1 Time Limit For Filing Claims

Medicaid requires all claims for private duty-nursing providers to be filed within one year of the date of service. Refer to Section 5.1.5, Filing Limits and Approved Exceptions, for more information regarding timely filing limits and exceptions.

31.5.2 Diagnosis Codes

The *International Classification of Diseases - 10th Revision - Clinical Modification* (ICD-10-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, AMA Plaza 330 North Wabash Ave, Suite 39300 Chicago, IL 60611-5885, or 1-800-621-8335.

NOTE:

ICD-9 codes should be used for claims submitted with dates of service prior to or equal to 09/30/2015.

ICD-10 codes should be used for claims submitted with dates of service on/after 10/01/2015.

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NOTE:

ICD-9 or ICD-10 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

31.5.3 Procedure Codes

Private duty-nursing providers use the Current Procedural Terminology (CPT) coding system. The CPT manual lists most Medicaid required procedure codes. This manual may be obtained by contacting the Order Department, American Medical Association, 515 North State Street, Chicago, IL 60610-9986.

The following revenue codes and procedure codes apply when filing claims for private duty-nursing services:

Revenue Code	*Procedure Code*	*Description*
551	S9123/Modifier EP	Private Duty Nurse/RN
551	S9124/Modifier EP	Private Duty Nurse/LPN

31.5.4 Place of Service Codes

Place of services codes do not apply when filing the UB-04 claim form.

31.5.5 Required Attachments

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

- Claims With Third Party Denials

NOTE:

When an attachment is required, a hard copy UB-04 claim form must be submitted.

Refer to Section 5.8, Required Attachments, for more details about these attachments.

31.6 For More Information

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

Resource	Where to Find it
UB-04 Claim Filing Instructions	Chapter 5
Institutional Medicaid/Medicare-related Claim Filing Instructions	Chapter 5
Medical Necessity/Medically Necessary Care	Chapter 7
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
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32 Provider-Based Rural Health Clinics

Rural health clinics are defined as clinics located in a rural area designated by the Bureau of Census as non-urbanized and medically under-served. Rural health clinics are designed to meet the needs of those recipients who might otherwise be unable to access medical attention.

Provider based rural health clinics are clinics that are an integral part of hospital, home health agency, or nursing facility. Provider-based rural health clinics are reimbursed on an encounter rate for services provided to Medicaid recipients.

Refer to the following chapters of the *Alabama Medicaid Agency Administrative Code*:

- Chapter 59 for policy for provider-based rural health clinics
- Chapter 60 for reimbursement policy

32.1 Enrollment

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

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

National Provider Identifier, Type, and Specialty

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

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

NOTE:
The 10-digit NPI is required when filing a claim.

Rural health clinics are assigned a provider type of 58 and valid specialty is 185.

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NOTE:

Physicians affiliated with rural health clinics are enrolled with their own NPI, which links them to the clinic. The provider type for the physician is 58 (Rural Health Clinic). The valid specialties are any of those specialties valid for physicians. Please refer to Chapter 28, Physician, for a listing of valid specialties.

All other personnel affiliated with the rural health clinic, such as physician assistants or nurse practitioners, bill using the clinic NPI, and are not assigned individual NPIs.

Enrollment Policy for Provider-Based Rural Health Clinics

In order to participate in the Title XIX (Medicaid) Program, and to receive Medicaid payment, a provider-based rural health clinic must:

- Receive certification for participation in the Title XVIII (Medicare) Program
- Obtain certification by the appropriate State survey agency
- Comply with the Clinical Laboratory Improvement Amendment (CLIA) testing for all laboratory sites
- Operate in accordance with applicable federal, state and local laws.

All clinics must enroll separately and execute a separate provider contract with Alabama Medicaid.

The effective date of enrollment of a provider-based rural health clinic will be the date of Medicare certification. Providers who request enrollment more than 120 days after certification are enrolled on the first day of the month the enrollment is approved.

The provider based rural health clinic must be under the medical direction of a physician. The physician must be physically present at the clinic for sufficient periods of time to provide medical care services, consultation, and supervision in accordance with Medicare regulations for rural health clinics. A *sufficient period* is defined as follows:

- No less than once every 72 hours for non-remote sites
- At least once every seven days for remote sites

Remote sites are defined as those more than 30 miles from the primary supervising physician's principal practice location.

This requirement must be accommodated except in extraordinary circumstances. The clinic must fully document any extraordinary circumstances that prevent it from meeting this requirement.

When not physically present, the physician must be available at all times through direct telecommunication for consultation, assistance with medical emergencies or patient referral.

Change of Ownership (CHOW) and Closures

Medicaid will mirror Medicare's Change of Ownership (CHOW) policy. Refer to Chapter 19, Hospital for additional information on Change of Ownership.

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The new owner may choose to accept the established reimbursement rate or submit a budgeted cost report to the Medicaid Agency and must submit his choice in writing to Medicaid's Provider Audit Program within the 30 calendar days timeframe of the change of ownership.

- 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 PCP 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)
- 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-**Alabama Coordinated Health Network (ACHN)** 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 **ACHN** Program should be listed on the enrollment form.

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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. Refer to Chapter 7, Understanding Your Rights and Responsibilities as a Provider, for general criteria on Medical Necessity/ Medically Necessary Care.

32.2.1 Covered Services

Rural health clinic visits and inpatient physician services are subject to the same routine benefit limitations as for physicians. Refer to the *Alabama Medicaid Agency Administrative Code,* Chapter 6, for details.

The following services are covered in the provider-based rural health clinic:

- Medically necessary diagnostic and therapeutic services and supplies that are an incident to such services or as an incident to a physician's service and that are commonly furnished in a physician's office or a physician's home visit.
- Basic laboratory services essential to the immediate diagnosis and treatment of the patient that must include but are not limited to the following six tests that must be provided directly by the rural health clinic:
  - Chemical examinations of urine by stick or tablet methods or both (including urine ketones)
  - Hemoglobin or hematocrit
  - Blood glucose
  - Examination of stool specimens for occult blood
  - Pregnancy tests
  - Primary culturing for transmittal to a certified laboratory
- Medical emergency procedures as a first response to life threatening injuries and acute illness.
- Provider based rural health services may be provided by any of the following individuals:
- Physician
- Physician assistant, nurse practitioner, certified nurse midwife, or registered nurse

The physician, physician assistant, nurse practitioner, certified nurse midwife, or registered nurse must conform to all state requirements regarding the scope or conditions of their practice.

The CRNP can make physician-required visits to nursing facilities. However, a CRNP cannot make physician required inpatient visits to hospitals or other institutional settings to qualify for payment to the physician or to satisfy current regulations as physician visits. The PA or CRNP may provide low complexity or straightforward medical decision-making services in the emergency department or assist at surgery (identified surgical codes only) for Medicaid reimbursement.

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A nurse practitioner, physician assistant, or certified nurse midwife must furnish patient care services at least fifty (50%) percent of the time the clinic operates.

32.2.2 Reimbursement

PBRHC services are reimbursed by an all-inclusive encounter rate. All services provided for that date of service will be included in the encounter rate. If a recipient only has lab or x-rays, this will also constitute an encounter.

Encounters are face-to-face contacts between a patient and a health professional for medically necessary services.

Surgical procedures performed in place of service 21 (inpatient) or place of service 22 (outpatient) will be reimbursed fee-for-service.

Contacts with one or more health professionals and multiple contacts with the same health care professional that take place on the same day at a single location constitute a single encounter, unless the patient later suffers illness or injury requiring additional diagnosis or treatment.

Reimbursement for an enrolled out-of-state PBRHC will be the lesser of the encounter rate established by the Medicaid Department of the out-of-state PBRHC or the average encounter rate established by Alabama Medicaid for in-state facilities.

As described in Section 1902(aa) of the Social Security Act, PBRHCs will be paid under a prospective payment system rate (PPS rate) effective January 1, 2001. The rate setting period is from October 1 through September 30th. Each PBRHC is entitled to the payment amount (on a per visit basis) to which the PBRHC was entitled to in the previous fiscal year, increased by the percentage increase in the Medicare Economic Index (MEI) for primary care services, and adjusted to take into account any increase (or decrease) in the scope of services furnished by the PBRHC during that fiscal year.

If a service has been eliminated, the Health Center must notify Medicaid that they have discontinued a given service. Medicaid must be notified in writing within ninety (90) calendar days of any termination of service(s). The notification of discontinued service must include the 12-month cost report for the discontinued service leading up to the termination of the service. The Agency may request additional documentation. An elimination of a service or services will not result in a rate adjustment unless the elimination has a cost impact of 3%. Failure to notify Medicaid of a termination of service may result in recoupment of paid claims.

Deleted: ~~This decrease in…the PPS rate.~~
Added: An elimination of…impact of 3%

PBRHC services and other ambulatory services provided at the PBRHC will be reimbursed by an all-inclusive encounter rate. Refer to the *Alabama Medicaid Agency Administrative Code*, Chapter 60, for details.

Deleted: ~~NOTE: A deletion…CIS submission limitation.~~

Change in Scope (CIS)

A PBRHC may request that their PPS rate be adjusted to take into account a change (either increase or decrease) in the scope of services furnished by the PBRHC. A change in scope of services is defined as a change in the type, intensity, duration, and/or amount of services provided during a PBRHC visit. Change in Scope requests must meet regulatory compliance as required by state and federal law as it relates to the operation of PBRHC services provided under the Alabama Medicaid (“Medicaid”) Program.

Deleted: ~~Reimbursement for all…Rule 560-X-60.04.~~

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Added: Medicaid will not…documentation listed below.
Deleted: ~~should~~
Added: must
Deleted: ~~ninety (90)~~
Added: 180
Added: (six months)
Deleted: ~~twelve (12) months of CIS activity~~
Added: the Health Clinic's fiscal year end
Added: items clearly labeled and identified

A change in scope request must be sent to the Managed Care Operations Division for review. The request must specifically state what PBRHC service was changed, and specifically detail how the type, intensity, duration, or amount of that service has changed. Medicaid will not review the CIS request until a complete submission is received. A complete submission includes the documentation listed below. The CIS request must be submitted to the Agency no later than 180 days (six months) after the Health Clinic's fiscal year end. The request shall include, at a minimum, the following items clearly labeled and identified documentation:

1. Narrative of the Qualifying Event or Events including a description of the Event or Events and other relevant information such as the locations affected, the date new services began, time period over which the changes took place or how patients are impacted; any relevant supporting documentation should also be provided. The Health Clinic must specify their fiscal year period in the narrative that will be submitted with the CIS request. Failure to disclose the fiscal year in the narrative will result in an incomplete submission.

Added: The Health Clinic…an incomplete submission.

2. A CIS Medicaid cost report with at least 12-months of actual expenses associated with the requested change in scope

   - The Medicaid cost report must reflect ALL clinic visits. Also, initial supporting documentation must include the following:

     - General Ledger Detail (in excel format) for the period under audit
     - Trial Balance (in excel format)
     - Crosswalk of Trial Balance accounts to Medicaid cost report line item
     - Medicare Cost Report for period(s) consistent with the Medicaid Cost Report

Added: Medicare Cost Report…Medicaid Cost Report.

3. The PBRHC's proposed PPS rate with detailed documentation of how the proposed PPS rate was derived or calculated.
4. A listing of deleted services not reported to Medicaid, if applicable. Listing must include the deleted service and the date the service was deleted.

Deleted: ~~Other documentation as…by the Agency~~

The Medicaid Agency may request more documentation or clarification of the documentation provided. If the PBRHC fails or refuses to provide the documentation requested by the Medicaid Agency, the change in scope request may be denied. PBRHCs may submit one CIS request within 12-months of the last submitted CIS request.

Deleted: ~~PBRHCs shall only…state fiscal year.~~
Added: PBRHCs may submit…submitted CIS request.

NOTE:

A deletion in service(s) does not count towards the 12-month CIS submission limitation.

Added: NOTE: A deletion…Agency will notify

The Agency will notify the Health Clinic within seven days of receipt of a CIS request. If the Health Clinic does not receive a response within seven days, it is the Health Clinic's responsibility to reach out to the Agency regarding receipt of the CIS request. The Agency will review the CIS request to determine if the CIS request is complete. The Agency will notify the Health Clinic within 30 days regarding the completion status of the CIS request. The Agency will notify

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the Health Clinic within 60 days from CIS submission completion date of the approved qualifying events.

Added: the Health Clinic…scope rate adjustment.

A change in the scope of service occurs if the PBRHC has added or discontinued any service that meets the definition of PBRHC services as provided in Section 1905(a) (2) (B) and (C) of the Act, ***and*** the service is included as a covered Medicaid service under the Alabama Medicaid State Plan. A change in the scope of service is defined as a change in the type, intensity, duration and/or amount of services compared to the services offered at the time of the last change of scope rate adjustment.

Added: Type- the FQHC/RHC…to changing circumstances.

Type- the FQHC/RHC has added or dropped any service that meets the definition of FQHC/RHC services as provided in section 1905(a) (2) (B) and (C) of the Social Security Act or if the service is included as a covered Medicaid service in the State Plan.

Intensity- a change in the characteristics of services offered in an average visit such that the average patient receives a different array of services.

Amount- an increase or decrease in the quantity of services that an average patient receives in an average visit.

Duration- a change in the average length of time it takes medical providers to complete an average patient visit due to changing circumstances.

Deleted: The scope in…amount, or duration.

A change in scope review will not take increased costs or inflation into account. Further, Patient-Centered Medical Home (PCMH) certification will not qualify for a rate adjustment. When the cost of the changed service has been determined, the incremental/decremental rate adjustment to the individual service will be combined into the overall PPS rate thereby calculating a revised encounter rate. Only the services that changed will be included in the PPS rate calculation during the change in scope request review. If the new PPS rate results in an overall increase or decrease of at least 3 percent of the PPS rate at the time Medicaid receives the change in scope request, then the PPS rate will be adjusted. The effective date of the new PPS rate will be the first day of the month that the Medicaid Agency receives a completed CIS request. The Agency will notify the health clinic within 30 days if the CIS request is complete or not. A complete submission includes the documentation listed above.

Deleted: ~~The new PPS…final rate determination~~
Added: The effective date…by May 1st.

NOTE:

For example: if a CIS request is received on March 31, but does not contain all required information, it will be returned. On May 15th, the Agency receives the resubmitted CIS request with all required documentation, therefore the effective date will be May 1st.

The PBRHC must demonstrate the following:

- a cost impact per qualifying event or a combination of more than one qualifying event and
- the incremental cost impact per visit to the change in scope of service.

Any costs supporting the rate adjustment must be allowable for PBRHCs under the Administrative Code Chapter 60- Provider-Based Rural Health Clinic

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Reimbursement. The calculated incremental cost per visit of the change in scope will be applied to the PPS rate currently in effect.

A Change in Scope request may take more than a period of one year to process; however, the Agency anticipates processing change in scope requests within 6 months. For additional information, please contact the Managed Care Operations Division.

NOTE:

New PPS rates due to an approved change in scope will be based on the incremental and/or decremental costs of the approved qualifying event(s).

Family Planning

- Family planning services are services provided to prevent or delay pregnancy.
- The Plan First visit will be reimbursed at the encounter rate when billed.
- Complete guidelines for family planning are in the Provider Billing manual, Appendix C.

1st Look - The Oral Health Risk Assessment and Dental Varnishing Program

For additional Oral Health Risk Assessment and Dental Varnishing information and guidelines please refer to Medicaid's Provider Manual's Dental Chapter 13.

32.3 Prior Authorization and Referral Requirements

Procedure codes billed by rural health providers generally do not require prior authorization. Any service warranted outside of these codes must have prior authorization. Refer to Chapter 4, Obtaining Prior Authorization, for general guidelines.

When filing claims for recipients enrolled in the ACHN Program, refer to Chapter 40, to determine whether your services require a referral from the Primary Care Physician (PCP).

32.4 Cost Sharing (Copayment)

The copayment amount $3.90 per visit including crossovers. The copayment does not apply to services provided for pregnant women, nursing facility residents, recipients less than 18 years of age, emergencies, and family planning. Native American Indians that present an "active user letter" issued by Indian health Services (IHS) will be exempt from the Medicaid required copayment.

Providers may not deny services to any eligible Medicaid recipient because of the recipient's inability to pay the cost-sharing (copayment) amount imposed.

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NOTE:

Medicaid copayment is NOT a third party resource. Do not record copayment on the CMS-1500 claim form.

Medicare Deductible and Coinsurance

For provider-based rural health clinic services, Medicaid pays the Medicare deductible and coinsurance up to the encounter rate established by Medicaid.

32.5 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

Provider-based rural health clinics that bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When filing a claim on paper, a CMS-1500 claim form is required. Medicare-related claims must be filed using the Medical Medicaid/Medicare-related Claim Form.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

32.5.1 Time Limit for Filing Claims

Medicaid requires all claims for provider-based rural health clinics to be filed within one year of the date of service. Refer to Section 5.1.5, Filing Limits, for more information regarding timely filing limits and exceptions.

32.5.2 Diagnosis Codes

The *International Classification of Diseases - 10th Revision - Clinical Modification* (ICD-10-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, AMA Plaza 330 North Wabash Ave, Suite 39300 Chicago, IL 60611-5885, or 1-800-621-8335.

NOTE:

ICD-9 codes should be used for claims submitted with dates of service prior to or equal to 09/30/2015.

ICD-10 codes should be used for claims submitted with dates of service on/after 10/01/2015.

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NOTE:

ICD-9 or ICD-10 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

32.5.3 Procedure Codes and Modifiers

NOTE:

Provider based rural health provider should refer to Chapter 28, Physician, for procedure code information.

NOTE:

Providers should use procedure code 36415-90 for routine venipuncture collection, 36416-90 for collection of capillary blood specimen (eg, finger, heel, or ear stick) and Q0091-90 for collection of Pap smear specimen.

Collection of laboratory specimens may be billed only when sending specimens to another site for analysis if the other site is not owned, operated, or financially associated with the site in which the specimen was collected.

The collection fee may not be billed if the lab work is done at the same site where the specimen was collected or in a lab owned, operated, or financially associated with the site in which the specimen was collected.

Independent laboratory providers will not be paid for and should not submit claims for laboratory work done for them by other independent laboratories or by hospital laboratories.

Providers may submit claims for laboratory work done by them in their own laboratory facilities. Providers who send specimens to another independent laboratory for analysis may bill a collection fee. This fee shall not be paid to any provider who has not actually extracted the specimen from the patient.

Vaccines For Children (VFC)

Refer to Appendix A, EPSDT, for procedure codes for VFC.

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

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32.5.5 Required Attachments

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

- Claims With Third Party Denials

Refer to Section 5.8, Required Attachments, for more information on attachments.

32.6 For More Information

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

Resource	Where to Find It
CMS-1500 Claim Filing Instructions	Chapter 5
Medical Medicaid/Medicare-related Claim Filing Instructions	Chapter 5
Medical Necessity/Medically Necessary Care	Chapter 7
EPSDT	Appendix A
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
Family Planning	Appendix C
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N

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33 Psychiatric Treatment Facilities

The policy provisions for psychiatric hospitals and psychiatric residential treatment facilities (PRTFs) may be found in Chapter 41 of the Medicaid Administrative Code. The complete administrative code is found on the Medicaid website: www.medicaid.alabama.gov.

Psychiatric services for recipients under age 21 are covered services when provided under the following conditions:

- Under the direction of a physician
- By a psychiatric hospital enrolled as a Medicaid provider **OR**

  By a psychiatric residential treatment facility (PRTFs) which is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Commission on Accreditation of Rehabilitation Facilities (CARF), the Council on Accreditation of Services for Families and Children (COA), or by another accrediting organization with comparable standards that is recognized by the State;
- Before the recipient reaches age 21
- If the recipient was receiving services immediately before he/she reached age 21, before the earlier of the following dates:
  - The date the recipient no longer requires the services
  - The date the recipient reaches age 22
  - The expiration of covered days
    - To a recipient admitted to and remaining in the facility for the course of the hospitalization
    - As certified in writing to be necessary in the setting in which it will be provided in accordance with 42 CFR 441.152.

33.1 Enrollment

Gainwell enrolls psychiatric hospital providers and issues provider contracts to applicants meeting the licensure and certification requirements of the State of Alabama, the Code of Federal Regulations, the *Medicaid Administrative Code*, and the *Medicaid Provider Manual*.

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

Federal requirements mandate providers re-validate periodically with the Alabama Medicaid program. Providers will be notified when they are scheduled to re-validate. Failure to re-validate and provide appropriate documentation to complete enrollment will result in an end-date being placed

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on the provider file. Once a provider file has been closed for failure to timely re-validate, providers will have to submit a new application for enrollment.

National Provider Identifier, Type, and Specialty

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

Psychiatric hospitals and PRTFs are assigned a provider type of 01 (Hospital). The valid specialty for psychiatric hospitals is (017) and (013) for PRTFs.

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

Enrollment Policy for Psychiatric Residential Treatment Facilities (PRTFs)

To participate in the Alabama Medicaid program, PRTFs must meet the following conditions:

- Be accredited by JCAHO, CARF, COA, or be certified as an Alabama PRTF in accordance with standards promulgated by the Alabama Department of Human Resources (DHR), the Department of Mental Health (DMH), or the Department of Youth Services (DYS), or the Department of Children's Services (DCA). Upon enrollment and each time the PRTF is recertified a copy of the certification letter must be sent to Medicaid within forty-five business days.
- Be in compliance with Title VI and VII of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975
- Execute a contract or placement agreement with DHR, DMH, DYS, or DCA to provide residential psychiatric treatment services in the State of Alabama

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- Execute a provider agreement with Alabama Medicaid to participate in the Medicaid program;
- Submit a written description of an acceptable UR plan currently in effect
- Submit a written attestation of compliance with the requirements of 42 CFR, Part 483, Subpart G, regarding the reporting of serious occurrences and the use of restraint and seclusion upon enrollment and yearly on or before July 21;
- Be in compliance with staffing and medical record requirements necessary to carry out a program of active treatment for individuals under age 21.

All correspondence regarding application by Alabama PRTFs for participation in the Medicaid program should be mailed to:

Alabama Medicaid Agency
Attention: Institutional Services
PO Box 5624
Montgomery, AL 36103.

Change of Ownership (CHOW) and Closures

Medicaid will mirror Medicare's Change of Ownership (CHOW) Policy Refer to Chapter 19, Hospital for additional information on Change of Ownership

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. Refer to Chapter 7, Understanding Your Rights and Responsibilities as a Provider, for general criteria on Medical Necessity/ Medically Necessary Care.

For purposes of this chapter, an inpatient is a person admitted to a psychiatric facility for bed occupancy for purposes of receiving inpatient or residential psychiatric services.

The number of days of care charged to a recipient for inpatient psychiatric services is always a unit of a full day. A day begins at midnight and ends 24 hours later. The midnight to midnight method is used to report days of care for the recipients, even if the facility uses a different definition of day for statistical or other purposes.

Medicaid covers the day of admission, but not the day of discharge.

When a recipient is discharged and admitted to the same hospital on the same date of service, the hospital should completely discharge the recipient and then readmit on separate UB-04's (even if the readmission was for the same diagnosis).

If a recipient is discharged to a general hospital, the psychiatric facility must not bill Medicaid for those non covered days.

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33.2.1 Therapeutic Visits

Therapeutic visits away from the psychiatric hospital to home, relatives, or friends are authorized if certified by the attending physician as medically necessary in the treatment of the recipient. An admission to a general hospital does not count as a therapeutic visit. Therapeutic visits are subject to the following limitations:

- No more than three days in duration
- No more than two visits per 60 calendar days per admission, per recipient

Therapeutic visit records will be reviewed retrospectively by Medicaid. Medicaid will recoup payments from providers who receive payments for therapeutic visits in excess of the amount as described above. This policy applies only to visits away from the psychiatric hospital. Visits away from the PRTF are not limited by this policy.

33.3 Certification of Need for Inpatient and Residential Services

Providers should refer to Chapter 41 of the Medicaid Administrative Code for complete instructions on documenting the certification of need for inpatient or residential treatment services. Instructions for documenting emergency and non-emergency admissions to PRTFs will also be found in Chapter 41.

All entries in the medical record must be legible and complete, and must be authenticated and dated promptly by the person (identified by name and discipline) who is responsible for ordering, providing, or evaluating the service furnished. The author of each entry must be identified and must authenticate his or her entry. Authentication may include signatures, written initials, or computer entry.

Reimbursement

Medicaid pays for inpatient services provided by psychiatric hospitals according to the per diem rate established for the hospital. The per diem rate is based on the Medicaid cost report and the provisions documented in the *Medicaid Administrative Code,* Chapter 23.

Providers are required to file a complete uniform Medicaid cost report for each fiscal year. Medicaid must receive one copy of this report within three months after the Medicaid year-end cost report.

Hospitals that terminate participation in the Medicaid program must provide a final cost report within 120 days of the date of termination of participation.

If a uniform cost report is not filed by the due date, the hospital shall be charged a penalty of $100.00 per day for each calendar day after the due date.

Medicaid pays for residential treatment services provided by PRTFs according to the per diem rate established in the placement agreement between the PRTF and the contracting state agency (DHR, DYS, DMH, DCA).

Provider Preventable Conditions (PPCs)

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Provider Preventable Conditions (PPCs) are clearly defined into two separate categories: Healthcare Acquired Conditions and Other Provider Preventable Conditions (OPPCs)

Healthcare Acquired Conditions include Hospital Acquired Conditions (HACs).

OPPCs include but are not limited to the following; surgery on a wrong body part, wrong surgery on a patient, surgery on a wrong patient.

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

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

- The PPC must be reasonably preventable as determined by a root cause analysis or some other means.
- The PPC must be within the control of the provider.
- The PPC must be clearly and unambiguously the result of a preventable mistake made and hospital procedures not followed, and not an event that could otherwise occur.
- The PPC must result in significant harm. The OPPCs for consideration should be limited to those that yield a serious adverse result. Serious adverse result is defined as one that results in death, a serious disability or a substantial increase in the duration and/or complexity of care that is well beyond the norm for treatment of the presenting condition. A serious disability is defined as a major loss of function that endures for more than 30 days, is not present at the time services were sought and is not related to the presenting condition.
- Any process for identifying non-payable events must actively incorporate some element of case-by-case review and determination. While the source and cause of some OPPCs may be clear, most would require further investigation and an internal root cause analysis to determine the cause of the serious preventable event and to assign ultimate accountability.

Pursuant to these guidelines, hospitals will not seek payments for additional days directly resulting from a PPC.

Reporting Other Provider-Preventable Conditions (OPPCs).

The following OPPCs must be reported to Medicaid by encrypted emailing of the required information to: *mailto:AdverseEvents@medicaid.alabama.gov*.

Each hospital will receive a password specifically for e-mail reporting. Reportable "OPPCs" include but are not limited to:

- Surgery on a wrong body part

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

Reports will require the following information: Recipient first and last name, date of birth, Medicaid number, date event occurred and event type. A sample form is on the Alabama Medicaid Agency website at: http://medicaid.alabama.gov/content/4.0_Programs/4.4_Medical_Facilities/4.4.1_Hospital_Services/4.4.1.3_Adverse_Events.aspx although hospitals may submit their own form as long as it contains all required information.

NOTE:

***Reporting is required only when not filing a UB-04 claim.**

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

Psychiatric hospitals and PRTF's should use the POA indicator on claims for these HACs as identified by Medicare other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients. If no claim is submitted for the event or the event cannot be filed on a UB-04 claim form, then the Alabama Medicaid Agency is to be notified via encrypted e-mail at AdverseEvents@medicaid.alabama.gov . The following information will be required: Recipient first and last name, date of birth, Medicaid number, date of event occurrence and event type. A sample form can be found on the Alabama Medicaid Agency website or a hospital may submit their own form as long as it contains all of the required information. Below are Hospital Acquired Conditions (HACs) with ICD-9 Codes that hospitals are required to report on the UB-04 claim form:

Selected HAC	CC/MCC (ICD-9-CM Codes)	CC/MCC (ICD-10-CM Codes)
Foreign Object Retained After Surgery	998.4 (CC) and 998.7 (CC)	T81.500A to T81.599A T81.60XA to T81.69XA
Air Embolism	999.1 (MCC)	T80.0XXA
Blood Incompatibility	999.60 (CC) 999.61 (CC) 999.62 (CC) 999.63 (CC) 999.69 (CC)	T80.30XA T80.319A T80.310A T80.311A T80.39XA
Pressure Ulcer Stages III & IV	707.23 (MCC) and 707.24 (MCC)	L89.003 to L89.93 L89.004 to L89.94
Falls and Trauma: -Fracture -Dislocation -Intracranial Injury -Crushing Injury -Burn -Electric Shock	Codes within these ranges on the CC/MCC list: 800-829 830-839 850-854 925-929 940-949 991-994	 S02.0XXA to T07 S03.0XXA to S91.109A S06.0X0A to S01.90XA S07.0XXA to S77.20XA T26.50XA to T32.99 T33.011A-T70.9XXA
Catheter-Associated Urinary Tract Infection (UTI)	996.64—Also excludes the following from acting as a CC/MCC: 112.2 (CC), 590.10 (CC), 590.11 (MCC), 590.2 (MCC), 590.3 (CC), 590.80 (CC), 590.81 (CC), 595.0	T83.51XA B37.41 to B37.49 N10

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Selected HAC	CC/MCC (ICD-9-CM Codes)	CC/MCC (ICD-10-CM Codes)
	(CC), 597.0 (CC), 599.0 (CC)	N10 N15.1 N28.84 to N28.86 N11.9 to N13.6 N16 N30.00 and N30.01 N34.0 N39.0
Vascular Catheter-Associated Infection	999.31 (CC) 999.32 (CC) 999.33 (CC)	T80.218A to T80.219A T80.211A T80.212A
Manifestations of poor glycemic control	250.10-250.13 (MCC), 250.20-250.23 (MCC), 251.0 (CC), 249.10-249.11 (MCC), 249.20-249.21 (MCC)	E10.10 to E13.10 E11.00 to E13.01 E15 E08.00 to E13.10 E08.00 to E13.01
Surgical Site Infection, Mediastinitis, Following Coronary Artery Bypass Graft (CABG)	519.2 (MCC) and one of the following procedure codes: 36.10-36.19.	J98.5 See CMS website for listing of associated Procedure Codes
Surgical Site Infection Following Certain Orthopedic Procedures	996.67 (CC) 998.59 (CC) And one of the following procedure codes: 81.01-81.08, 81.23. 81.24 81.31-81.38, 81.83, 81.85	T84.60XA to T84.7XXA K68.11 to T81.4XXA See CMS website for listing of associated Procedure Codes
Surgical Site Infection Following Bariatric Surgery for Obesity	Principal Diagnosis code-278.01, 539.01 (CC), 539.81 (CC) OR 998.59 (CC) and one of the following procedure codes: 44.38,44.39, or 44.95	Principal Diagnosis code E6601 and one of the secondary diagnosis codes: K68.11, K9501, K9581 or T81.4XXA See CMS website for listing of associated Procedure Codes
Surgical Site Infection Following Cardiac Implantable Electronic Device (CIED)	996.61 (CC) or 998.59 (CC) And one of the following procedure codes: 00.50, 00.51, 00.52, 00.53, 00.54, 37.80, 37.81, 37.82, 37.83, 37.85, 37.86, 37.87, 37.94, 37.96, 37.98, 37.74, 37.75, 37.76, 37.77, 37.79, 37.89	K68.11, T814XXA. T826XXA, T827XXA See CMS website for listing of associated Procedure Codes
Deep Vein Thrombosis and Pulmonary Embolism Following Certain Orthopedic Procedures	415.11 (MCC), 415.13 (MCC), 415.19 (MCC), or 453.40-453.42 and one of the following procedure codes: 00.85-00.87, 81.51-81.52, or 81.54.	T80.0XXA to T82.818A I26.90, I2699 I26.09, I26.99 I82.401 to I82.4Z9 See CMS website for listing of associated Procedure Codes
Iatrogenic Pneumothorax with Venous Catheterization	512.1 (CC) And the following procedure code 38.93	J95.811 and one of the following procedure codes: 05HM33Z 05HN33Z 05HP33Z 05HQ33Z 0JH63XZ

For ICD-10, please use the CMS Diagnosis Listing for POA Exempt Diagnosis Codes at:
https://www.cms.gov/Medicare/Coding/ICD10/index.html

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Select the appropriate fiscal year ICD-10-CM POA Exempt file for the dates of service on the claim. These codes are for recipient encounters occurring between October 1st through September 30th of each fiscal year.

All Diagnosis codes NOT present in the listing require POA indicator.

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

Non-payment of provider preventable conditions shall not prevent access to services for Medicaid beneficiaries.

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

Reductions in Provider payment may be limited to the extent that the following apply:

- The Identified PPC would otherwise result in an increase in payment.
- Psychiatric hospitals and PRTFs are paid based on a daily per diem rate. It is the responsibility of the hospital to identify any Health Care-Acquired Condition and not seek payment for any additional days that have lengthened a recipient's stay due to a PPC. In reducing the amount of days: Hospitals are to report a value code of '81' on the UB-04 claim form along with any non-covered days and the amount field must be greater than '0'.

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

- **Y**-Yes. Diagnosis was present at time of inpatient admission.
- **N**-No. Diagnosis was not present at time of inpatient admission.
- **U**-No information in the record. Documentation insufficient to determine if the condition was present at the time of inpatient admission.
- **W**-Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission.

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

A document with frequently asked questions has been posted on the Agency's website under Programs/Hospital Services.

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33.4 Cost Sharing (Copayment)

Copayment does not apply to services provided by inpatient psychiatric hospitals or PRTFs.

33.5 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

Psychiatric hospitals and PRTFs billing Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When filing a claim on paper, a UB-04 claim form is required. Medicare-related claims must be filed using the Institutional Medicaid/Medicare-related Claim Form.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

33.5.1 Time Limit for Filing Claims

Medicaid requires all claims to be filed within one year of the date of service. Refer to Section 5.1.5, Filing Limits, for more information regarding timely filing limits and exceptions.

33.5.2 Diagnosis Codes

The *International Classification of Diseases - 10th Revision - Clinical Modification* (ICD-10-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, AMA Plaza 330 North Wabash Ave, Suite 39300 Chicago, IL 60611-5885, or 1-800-621-8335.

NOTE:

ICD-9 codes should be used for claims submitted with dates of service prior to or equal to 09/30/2015.

ICD-10 codes should be used for claims submitted with dates of service on/after 10/01/2015.

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NOTE:

ICD-9 or ICD-10 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field. Only the diagnosis codes within the range of 290-316 are covered for services under this program.

33.5.3 Revenue Codes

Refer to the Alabama UB-04 Manual, published by the Alabama Hospital Association, for a complete list of revenue codes.

33.5.4 Place of Service Codes

Place of service codes do not apply when filing the UB-04claim form.

33.5.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to claims with Third Party Denials.

NOTE:

When an attachment is required, a hard copy UB-04 claim form must be submitted.

Refer to Section 5.8, Required Attachments, for more information on attachments.

33.6 For More Information

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

Resource	Where to Find It
UB-04 Claim Filing Instructions	Chapter 5
Institutional Medicaid/Medicare-related Claim Filing Instructions	Chapter 5
Medical Necessity/Medically Necessary Care	Chapter 7
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 Behavioral Health

Licensed psychologists and licensed social workers are enrolled for services provided to QMB recipients or to recipients under the age of 21 referred as a result of an EPSDT screening. Licensed counselors and licensed marriage and family therapists are enrolled only for services provided to recipients under the age of 21 referred as a result of an EPSDT screening. The policy provisions for psychologists can be found in the *Alabama Medicaid Agency Administrative Code,* Chapter 11.

For those providers seeking to render ABA Therapy services, please refer to Chapter 37 Therapy (Occupational, Physical, Speech and ABA).

Federal regulations require that the State make provisions for handling of recoupments and recoveries. The Alabama Medicaid Agency will actively seek recovery of all misspent Medicaid funds and correctly paid benefits recoverable under Federal law; this statement will apply to the entire Alabama Medicaid Agency Provider Manual Chapter 34. For further understanding of recoupments, recoveries, and liens please refer to Alabama Medicaid Agency Administrative Code, Chapter 33.

The purpose of the recoupments, recoveries and liens effort is to assure that the State and Federal dollars allocated for medical assistance are spent only on those individuals who meet all eligibility criteria; to correct erroneous payments; and to recover benefits correctly paid, but recoverable by law; this statement will apply to the entire Alabama Medicaid Agency Provider Manual Chapter 34. For further understanding of recoupments, recoveries, and liens please refer to Alabama Medicaid Agency Administrative Code, Chapter 33.

34.1 Enrollment

Gainwell enrolls Psychologists and Behaviorial 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.

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

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National Provider Identifier, Type, and Specialty

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

NOTE:

All ten digits are required when filing a claim.

Psychology providers are assigned a provider type of 54 (Psychologist). Valid specialties for psychology providers include the following:

- Psychology (112)
- QMB/EPSDT (600)

Behavioral Health providers are assigned a provider type of 07 (Behavioral Health). Valid specialties for behavioral health providers include the following:

- Licensed Professional Counselor / LPC (070)
- Associate Licensed Counselor / ALC (071)
- Licensed Marriage and Family Therapist / LMFT (072)
- Licensed Marriage and Family Therapist Associate / LMFTA (075)
- Licensed Master Social Worker / LMSW (073)
- Licensed Independent Clinical Social Worker / LICSW (074)
- Licensed Psychological Technician / LPT (076)
- QMB/EPSDT (600)

Enrollment Policy for Psychologists and Behavioral Health Providers

Psychology and Behavioral Health providers must meet the following requirements for direct enrollment and participation in Medicaid:

- **Psychologists** – must possess a doctoral degree in psychology from an accredited school or department of psychology; Have a current license issued by the Alabama Board of Examiners in Psychology to practice as a psychologist and operate within the scope of practice as established by the Alabama Board of Examiners in Psychology.
- **Professional Counselor** – must possess a masters degree (or above) in counseling from an accredited school; Have a current license issued by the Alabama Board of Examiners in Counseling to practice as a counselor (LPC, ALC) and operate within the scope of practice as established by the Alabama Board of Examiners in Counseling.
- **Marriage and Family Therapist** - must possess a masters degree (or above) in marriage and family therapy from an accredited school; Have a current license issued by the Alabama Board of Examiners in Marriage and Family Therapy to practice as a marriage and family counselor

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(LMFT, LMFTA) and operate within the scope of practice as established by the Alabama Board of Examiners in Marriage and Family Therapy.

- **Social Worker** - must possess a masters degree (or above) in social work from an accredited school; Have a current license issued by the Alabama State Board of Social Work Examiners to practice as a social worker (LMSW, LICSW) and operate within the scope of practice as established by the Alabama State Board of Social Work Examiners.
- **Psychological Technician** - must possess a masters degree (or above) in psychology from an accredited school or department of psychology; Have a current license issued by the Alabama Board of Examiners in Psychology to practice as a licensed psychological technician (LPT) and operate within the scope of practice as established by the Alabama Board of Examiners in Psychology. {Must maintain supervision requirements as outlined by the Alabama Board of Examiners in 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. Refer to Chapter 7, Understanding Your Rights and Responsibilities as a Provider, for general criteria on Medical Necessity/ Medically Necessary Care.

Medicaid bases reimbursement of services on a fee for service for the procedure codes covered for behavioral health providers.

Behavioral Health services are only covered for QMB recipients (psychologists, licensed social workers), recipients referred directly as a result of an EPSDT screening (psychologists, licensed counselors, licensed marriage and family therapists) or recipients referred cascading by the psychologist (LMSW, LICSW). Treatment eligibility is limited to individuals with a diagnosis within the ICD-10 code range of F0150-F069 or F080-F099, assigned by a licensed physician, a licensed psychologist, a licensed physician's assistant, a certified registered nurse practitioner, a licensed counselor or a licensed marriage and family therapist (as approved by a psychologist) as listed in the most current International Classification of Diseases.

Added: licensed marriage and family therapists
Deleted: ~~LMFT~~

The provider agrees when billing Medicaid for a service that the provider 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 recipients, made before Medicaid pays, which are to be refunded after Medicaid pays, are not permissible. The provider may not charge a recipient or any financially responsible relative or representative of the recipient for Medicaid-covered services, except where a copayment is authorized under the Medicaid State Plan. (42 C.F.R. §447.20). The provider (or its 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. If a provider routinely accepts a Medicaid assignment, he or she may not bill Medicaid or the recipient for a service he or she did not provide, i.e., missed or canceled appointment.

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Payments from Medicaid funds can be made only to providers of the services; therefore, no reimbursement can be made to patients who may personally pay for the service rendered.

NOTE:

Behavioral Health providers can bill only those procedures listed in Section 34.6.3, Procedure Codes and Modifiers. Only the diagnosis codes within the range of F0150-F069 or F080-F099 for ICD-10 are covered for treatment services under this program. Intellectual Disability diagnosis codes (F070-F079) are not covered for treatment services **except for Crisis Intervention (performed by a psychologist)**; however, Medicaid will cover diagnostic testing, status exam (96101-96103, 96116 and 96118-96120 even if the resulting diagnosis is Intellectual Disability.

NOTE:

Codes 90832, 90832+90785, 90834, 90834+90785, 90837, 90837+90785, 90846, 90847, 90849, and 90853 may be billed on a weekly basis; although limited to no more than 52 max units per year (combined).

***Exception: Procedure codes 90846, 90847, 90849 and 90853 may be billed on the same date of service as other codes listed in the group above as per CPT® guidelines.**

The Alabama Medicaid Agency will not cover the following therapies as a stand-alone service:

- Equine assisted psychotherapy
- Biofeedback therapy
- Neurobiofeedback therapy
- Sleep therapy
- Dance therapy
- Music therapy
- Art therapy
- Play therapy

However, these therapies may be incorporated into the recipients counseling sessions for **no more than 50%** of the total time of the session. The start and stop time of each of the therapies (i.e. counseling vs alternative therapy) must be clearly documented. If the person administering one of the above therapies is different from the person providing the counseling, the name and credentials of that individual will need to be documented in the progress note as well as a copy of the credentials in the employee file.

34.3 Service Provision

Deleted: ~~and the~~
Added: and LMFT

The Psychologist, LPC/ALC, and LMFT must receive a valid, completed EPSDT referral from the recipient's Primary Physician (PMP) in order to provide behavioral health services to a recipient. For additional information

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about the EPSDT referral form please refer to Appendix A Well Child Check-Up EPSDT.

In order to provide behavioral health services to a recipient, the LMFT, LMSW or LICSW must receive an Alabama Medicaid Psychology (AMP) Referral form from an Alabama Medicaid enrolled psychologist or may directly receive an EPSDT referral for a recipient with a documented diagnosis.

Medical documentation must be present in the recipient's medical record identifying the psychologist making the referral. The AMP Referral is valid for a maximum of one year from the date that the referral is completed. The referring psychologists signature **and** number of visits or months approved must be documented on the referral in order for the form to be considered a valid referral.

The AMP Referral Form and instructions for completing can be found here: http://www.medicaid.alabama.gov/content/4.0_Programs/4.2_Medical_Services/4.2.5_Health_Professionals/4.2.5.1_Psychologist_Billing.aspx.

Both the EPSDT and AMP Referral Form must be maintained on file and in the recipient's medical record.

Client Intake

An intake evaluation must be performed for each client considered for initial entry into any course of covered services. A fillable or printable version of this Medicaid approved tool (Diagnostic Intake Interview) can be downloaded at the following link: http://www.medicaid.alabama.gov/content/4.0_Programs/4.2_Medical_Services/4.2.5_Health_Professionals/4.2.5.1_Psychologist_Billing.aspx.

The intake evaluation process 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

A comprehensive behavioral health assessment must be conducted whenever a behavioral health or developmental screening indicates the presence of a behavioral health symptom(s). For assessments that require certifications and/or trainings beyond the users education, the certification/training must be successfully completed **prior to** the use/administration of the chosen behavioral health assessment tool(s). Failure to possess the required certifications and/or trainings will subject the

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provider to program integrity action up to and including recoupment.. Examples of screening tools that can be used include, but are not limited to:

- Beck Depression Inventory and Child Behavior Checklist
- Behavior Assessment System for Children, 2nd Edition (BASC-2)
- Brief Symptom Inventory (BSI)
- Brown Attention-Deficit Disorder Scales
- Child and Adolescent Needs and Strengths (CANS)
- Childhood Autism Rating Scale (CARS)
- Children's Depression Inventory (CDI)
- Likert Scale
- Minnesota Multiphasic Personality Inventory (MMPI)
- Parent-Child Interaction Assessment-II
- State-Trait Anger Expression Inventory-2 , Child & Adolescent (STAXI-2 C/A)
- Wechsler Intelligence Scale for Children-Fourth Edition (WISC-IV)

Treatment Planning

The intake evaluation process must result in the development of a written treatment plan completed by the fifth client visit.

The treatment plan shall:

- Identify the clinical issues that will be the focus of treatment
- Specify those services necessary to meet the client's needs (Services are defined as the specific CPT® code descriptions as outlined on the grid in Section 34.6.3 Procedure Codes and Modifiers)
- Include referrals as appropriate for needed services
- Identify expected outcomes toward which the client and therapist will work to have an effect on the specific clinical issues
- The (initial) Treatment Plan is valid when the recipient/legally responsible person **and** the person who developed the plan sign and date it. Unless clinically contraindicated, the recipient will sign or mark the treatment plan to document the recipient's participation in developing /revising the plan. If the recipient is under the age of 14 or adjudicated incompetent, the parent, foster parent or legal guardian must sign the treatment plan.

Deleted: ~~licensed marriage and family therapist or~~

Services must be specified in the treatment plan in order to be paid by Medicaid. The treatment plan can be developed and carried out by the licensed social worker ***after*** diagnosis has been approved or received from the physician or psychologist practicing with their scope of practice.

The psychologist and/or behavioral health provider must review the treatment plan once every three months to determine the client's progress toward treatment objectives, the appropriateness of the services furnished, and the need for continued treatment. This review shall be documented in the client's clinical record by notation on the treatment plan. This review shall note the treatment plan has been reviewed and updated or continued

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without change. Treatment plans being carried out by an allied mental health provider must be reviewed/approved by the associated psychologist. **All** treatment plans must be updated annually.

Treatment plan review is not a face-to-face service, therefore the recipient/or legally responsible person signature is not required. The quarterly treatment plan review may be conducted by the Psychologist, Behavioral Health provider or by another professional with the same credentialing (or above), such as a supervisor or a peer. Only the reviewing professionals' signatures (handwritten or associated computerized electronic health record {not typed} signature) or initials and dates are necessary. A stamped signature is not acceptable.

Service Documentation

Documentation in the client's record for each session, service, or activity for which Medicaid reimbursement is requested must include, the following:

- The identification of the specific services rendered (Services are defined as the specific CPT® code descriptions as outlined on the grid in Section 34.6.3 Procedure Codes and Modifiers)
- The date and the amount of time (time started and time ended---excluding time spent for interpretation of tests---applicable to psychologists only) that the services were rendered
- The signature of the staff person who rendered the services
- The identification of the setting in which the services were rendered
- A written assessment of the client's progress, or lack thereof, related to each of the identified clinical issues discussed
- All entries must be legible and complete, and must be authenticated and dated (***prior*** to being submitted for reimbursement) by the person (identified by name and discipline) who is responsible for ordering, providing, or evaluating the service furnished. The author of each entry must be identified and must authenticate his or her entry. Authentication may include handwritten signatures, written initials (for treatment plan reviews), or computer entry (associated with electronic records—not a typed signature). A stamped signature is not acceptable.

The list of required documentation described above will be applied to justify payment by Medicaid when clinical records are audited. Payments are subject to recoupment when the documentation is insufficient to support the services billed. LPCs/ALCs and LMFTs no longer require psychologist signatures on any documents related to the treatment of a Medicaid recipient.

Added: and LMFTs

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Service Documentation Additional Information

To further clarify service documentation questions/issues, please note the following:

Documentation

Documentation must not be repetitive (examples include, but are not limited to the following scenarios):

- Progress Notes that look the same for other recipients.
- Progress notes that state the same words day after day with no evidence of progression, maintenance or regression.
- Treatment Plans that look the same for other recipients.
- Treatment Plans with goals and interventions that stay the same and have no progression.

Progress Notes

- Progress Notes must not be ***preprinted*** or predated.
- The progress note must match the goals on the plan and the plan must match the needs of the recipient. The interventions must be appropriate to meet the goals. There must be clear continuity between the documentation.
- Progress Notes must provide enough detail and explanation to justify the amount of billing.

Treatment Plan

- The Treatment Plan must not be signed or dated prior to the plan meeting date.
- The Treatment Plan is valid when the recipient/legally responsible person **and** the person who developed the plan sign and date it.

Authentication

- Authors must always compose and sign their own entries (whether handwritten or electronic). An author should never create an entry or sign an entry for someone else or have someone else formulate or sign an entry for them. If utilizing a computer entry system, the program must contain an attestation signature line and time & date entry stamp. A stamped signature is not acceptable.

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- If utilizing a computer entry system, the program must contain an attestation signature line and time & date entry stamp. There must also be a written policy for documentation method in case of computer failure/power outage.

Corrections

- Corrections must be made legally and properly by drawing a line through the entry and making sure that the inaccurate information is still legible. Write "error" by the incorrect entry and initial. Do not obliterate or otherwise alter the original entry by blacking out with marker, using whiteout, or writing over an entry. White Out, Liquid Paper, or any form of correctional fluid or correctional tape is not acceptable on **any** records whether being used as a corrective measure or to individualize an original template or for any other reason.

Communication

- It is the responsibility of the provider to ensure that the primary care physician has been made aware of treatment plan goals by the fifth recipient visit, annually prior to EPSDT renewal; and, when requesting more than one therapy session per week. Documentation of communication will be required i.e. treatment note, fax confirmation sheet.

34.4 Prior Authorization and Referral Requirements

Psychology procedure codes generally do not require prior authorization. Any service warranted outside of these codes must have prior authorization. Refer to Chapter 4, Obtaining Prior Authorization, for general guidelines.

A current completed Alabama Medicaid Agency Referral Form must be present in the patient's medical record that identifies the treated conditions referred as the result of an EPSDT screening or payments for these services will be recouped. The referral form must be current and appropriately completed by the screening physician including the date that the problem was identified and the reason for the referral. Refer to Appendix A Sections 4.2 – 4.6.

Signature Requirement for Referrals: Effective May 16, 2012:
For hard copy referrals, the printed, typed, or stamped name of the primary care physician with an original signature of the physician or designee is required. **Stamped or copied signatures will not be accepted**. For electronic referrals, provider certification is made via standardized electronic signature protocol.

34.5 Cost Sharing (Copayment)

The copayment amount for office visit* including crossovers is:

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$3.90 for procedure codes reimbursed $50.01 and greater
$2.60 for procedure codes reimbursed between $25.01 and $50.00
$1.30 for procedure codes reimbursed between $10.01 and $25.00

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

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

If one of these CPT® codes is applicable for your practice, then copay applies.

Copayment does not apply to services provided for pregnant women, nursing facility residents, recipients less than 18 years of age, emergencies, and family planning. Native American Indians that present an "active user letter" issued by Indian Health Services (IHS) will be exempt from the Medicaid required copayment.

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

34.6 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

Behavior 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 CMS-1500 claim form is required. Medicare-related claims must be filed using the Medical Medicaid/Medicare-related Claim Form.

This section describes program-specific claims information. Providers should refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

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34.6.1 Time Limit for Filing Claims

Medicaid requires all claims for Behavioral Health 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.

34.6.2 Diagnosis Codes

The *International Classification of Diseases -10th Revision - Clinical Modification* (ICD-10-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, AMA Plaza 330 North Wabash Ave, Suite 39300 Chicago, IL 60611-5885, or 1-800-621-8335.

NOTE:

ICD-10 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field. Only the ICD-10 diagnosis codes within the range of F0150-F69 and F80-F99 are covered for services under this program.

34.6.3 Procedure Codes and Modifiers

The following procedure codes apply when filing claims for behavioral health services billed by a psychologist. The (837) Professional and Institutional electronic claims and the paper claim have been modified to accept up to four procedure code modifiers.

Claims without procedure codes or with invalid codes will be denied. Only the procedure codes/service descriptions listed in this section are covered under this program. Some codes are covered for QMB recipients only. Check the guidelines following this grid.

CPT® Code	***Description***	***See Note***	***Daily Max***	***Annual Max***
90791	Psychiatric diagnostic evaluation	1	1	1
90791 +90785	Psychiatric diagnostic evaluation with interactive complexity	1	1	1
90832	Psychotherapy, 30 minutes (16-37*) with patient	3, 9	1	This group of procedure codes may be billed on a weekly basis; although limited to no more than 52 max units per year total (combined) *See footnote 12

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CPT® Code	*Description*	*See Note*	*Daily Max*	*Annual Max*
90834	Psychotherapy, 45 minutes (38-52*) with patient	3, 9	1	*Exception: Procedure codes 90846, 90847, 90849 and 90853 may be billed on the same date of service as other codes listed in this group as per CPT guidelines.
90837	Psychotherapy 60 minutes (53+*) with patient	2, 3	1	
90832 +90785	Individual psychotherapy, 30 minutes (16-37*) with patient with interactive complexity services	3, 9	1	
90834 +90785	Psychotherapy, 45 minutes (38-52*) with patient with interactive complexity services	3, 9	1	
90837 +90785	Psychotherapy, 60 minutes (53+*) with patient with interactive complexity services	2, 3	1	
90846	Family psychotherapy (without the patient present), 50 minutes (26+)	4, 9		
90847	Family psychotherapy (conjoint psychotherapy) with patient present, 50 minutes (26+)	4, 9	1	
90849	Multiple-family group psychotherapy	4, 9	1	
90853	Group psychotherapy (other than of a multiple-family group)	5, 9	1	
H2011	Crisis Intervention	11	4	1,460
PSYCHOLOGICAL TESTING EVALUATION SERVICES BY PROFESSIONAL				
96130	Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report and interactive feedback to the patient, family member(s) or caregiver(s), when performed; **first hour**			5 units annually combined (with all related psychological testing codes)
96131	Each additional hour (List separately in addition to code for primary procedure)			
TEST ADMINISTRATION AND SCORING BY PROFESSIONAL				
96136	Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method, **first 30 minutes**			
96137	Each additional 30 minutes (List separately in addition to code for primary procedure)			
TEST ADMINISTRATION AND SCORING BY TECHNICIAN				
96138	Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; **first 30 minutes**			

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CPT® Code	*Description*	*See Note*	*Daily Max*	*Annual Max*
96139	Each additional 30 minutes (List separately in addition to code for primary procedure)			

NEUROPSYCHOLOGICAL TESTING EVALUATION SERVICES BY PROFESSIONAL				
96132	Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report and interactive feedback to the patient, family member(s) or caregiver(s), when performed; **first hour**			5 units annually combined (with all related neuropsychological testing codes)
96133	Each additional hour (List separately in addition to code for primary procedure)			
TEST ADMINISTRATION AND SCORING BY PROFESSIONAL				
96136	Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method, **first 30 minutes**			
96137	Each additional 30 minutes (List separately in addition to code for primary procedure)			
TEST ADMINISTRATION AND SCORING BY TECHNICIAN				
96138	Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; **first 30 minutes**			
96139	Each additional 30 minutes (List separately in addition to code for primary procedure)			
96116	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgement, e.g., acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities), by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report; **first hour**			
96121	Each additional hour (List separately in addition to code for primary procedure)			
96146	Psychological or neuropsychological test administration, with single automated instrument via electronic platform, with automated result only		1	1

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Reimbursable Codes for LPCs, LMFTs, LMSWs, LICSWs, and LPTs

Added: and LMFT

The following codes are billable by the above named behavioral health professionals operating within their scope of practice. 90791 (billable by the **LPC/ALC and LMFT** only); 90832, 90834, 90837 (and with 90785 add-on for interactive complexity), 90846, 90847, 96130/96131, 96132/96133, 96138/96139, 96146.

LPTs: 90791, 96130, 96131, 96138 and 96139

The description, notes and daily/annual limitations apply as listed in the above grid, and as outlined below. It is the responsibility of the provider to keep up with any and all updates and/or changes to CPT® and/or HCPCS ® codes applicable to billing.

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.

Guidelines for Covered Procedure Codes:

1. Codes 90791 and 90791+90785 have a combined annual max limitation of 1. The LICSW or LGSW may complete the Intake, but it must be reviewed **and** approved by the Psychologist, LPC or ALC. This code is billable by the psychologist, LPT, LPC, LMFT and ALC **only**.

Deleted: ~~LMFT~~

Added: LMFT

2. Please note 90837 / 90837+90785 are now the codes to be used to reflect 60 minutes of face-to-face time, and is included in the 52 unit annual max limitation.
3. Medicaid will not accept psychiatric therapy procedure codes 90832-90837 being billed on the same date of service as an E&M service by the same physician or mental health professional group.
4. Procedure codes 90847 and 90849 are used to describe family participation in the treatment process of the client. Code 90847 is used when the patient is present. Code 90849 is intended for group therapy sessions for multiple families when similar dynamics are occurring due to a commonality of problems in the family members in treatment. **Group therapy must be performed by a clinical psychologist licensed in the state of Alabama.** Group Therapy/Counseling progress notes must support that a process-oriented service involving group dynamics was provided.

   Family therapy is defined as the treatment of family members as a family unit, rather than an individual patient. When family therapy without the patient present (90846) or family therapy with the patient present (90847) is provided, the session is billed as one service (one family unit), regardless of the number of individuals present at the session. These codes are now time based, 50 minutes and a minimum of 26 minutes must be documented in the start and stop time in order to be billed.

   If there is more than one eligible child and no child is exclusively identified as the primary recipient of treatment, then the oldest child's recipient id number ***must*** be used for billing purposes. When a specific

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child is identified as the primary patient of treatment, that child's recipient ID number ***must*** be used for billing purposes. A family may be biological, foster, adoptive or other family unit.

A family is *not* a group and providers may *not* submit a separate claim for each eligible person attending the same family therapy session.

The therapist must document all attendees presence and participation.

All members of the family in attendance for the session will sign/mark the signature log or progress note to document their participation in the session (in addition to the therapist documenting their presence/participation).

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 performed by a clinical psychologist licensed in the state of Alabama.** Group Therapy/Counseling progress notes must support that a process-oriented service involving group dynamics was provided. Group Therapy/Counseling for children and/or adolescents may not exceed 10 (ten) recipients.

6. **Professional and Technical Activities Performed by the Psychologist**

   Please note that the new codes do not cross-walk on a one-to-one basis with the deleted codes. The single code, 96101, will now be billed using up to four (4) codes; two (2) codes for Psychological Evaluation Services (96130, 96131) and two (2) for Test Administration and Scoring (96136, 96137).

   Evaluation services include interpretation of test results and clinical data, integration of patient data, clinical decision making, treatment planning, report generation, and interactive feedback to the patient, family member(s) or caregiver(s).

   - The first hour of evaluation is billed using 96130 and each additional hour needed to complete the service is billed with code add-on 96131.
   - CPT® Time Rules allow an additional unit of a time-based code to be reported as long as the mid-point of the stated amount of time is passed. Beyond the first hour (96130), at least an additional 31 minutes of work must be performed to bill the first unit of the add-on code 96131.

   Evaluation services must always be performed by the professional prior to test administration, and must be billed on the last date of service, but documented in the medical record the actual date(s) the service is performed.
   Test administration and scoring services **performed by the psychologist** includes time spent to administer and score a minimum of two (2) psychological tests.

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- The first 30 minutes of test administration and scoring is billed using 96136 and each additional 30-minute increment needed to complete the service is billed with code 96137.
- CPT® time rules apply to the add-on code if, beyond the first 30 minutes, at least an additional 16 minutes of work is performed.

Professional Services Performed by the Psychologist and Technical Services Performed by Technician
Please note that the new codes do not cross-walk on a one-to-one basis with the deleted codes. The single code, 96102, will now be billed using four (4) codes; two (2) codes for Psychological Evaluation Services (96130, 96131) and two (2) for Test Administration and Scoring by Technician (96138, 96139).

Psychological Evaluation services include interpretation of test results and clinical data, integration of patient data, clinical decision making, treatment planning, report generation, and interactive feedback to the patient, family member(s) or caregiver(s).

- The first hour of evaluation is billed using 96130 and each additional hour needed to complete the service is billed with code add-on 96131.
- CPT® Time Rules allow an additional unit of a time-based code to be reported as long as the mid-point of the stated amount of time is passed. Beyond the first hour (96130), at least an additional 31 minutes of work must be performed to bill the first unit of the add-on code 96131.

Evaluation services must always be performed by the professional prior to test administration, and must be billed on the last date of service, but documented in the medical record the actual date(s) the service is performed.
Test administration and scoring services **performed by the Technician** includes time spent to administer and score a minimum of two (2) psychological tests.

- The first 30 minutes of test administration and scoring is billed using 96138 and each additional 30-minute increment needed to complete the service is billed with code 96139.
- CPT® time rules apply to the add-on code if, beyond the first 30 minutes, at least an additional 16 minutes of work is performed.

The units of measure for testing codes 96130 – 96131 has been changed from a 1 hour measurement increment to a 30 minute measurement increment, therefore when billing claims .5 units will equal 30 minutes; 1 unit will equal 1 hour; 1.5 units will equal 1 ½ hours, etc. Providers **cannot** bill less than a 30-minute increment. (*under daily max=combination of the codes).

Each test performed must be medically necessary; therefore, standardized batteries of tests are not acceptable. Nonspecific behaviors that do not indicate the presence of, or change in, a mental illness would not be an acceptable indication for testing. Psychological or psychiatric evaluations that can be accomplished through the clinical interview alone would not require psychological testing and such testing might be considered medically unnecessary. A psychological technician with

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adequate training may directly provide services listed in the **Code of Alabama Governing Psychologists** Section 34-26-1 without supervision; the licensed psychologist must sign the report. A licensed psychologist must be on-site where an allied mental health professional is performing testing services within their scope of practice, and the licensed psychologist must sign the report.

7. Intellectual Disability diagnosis codes (ICD-10 F70-F79) are not covered for treatment services; however, Medicaid will cover diagnostic testing, status exam (96130/96131, 96136/96137,96138/96139, 96116 and 96132/96133, 96136/96137, 96138/96139), even if the resulting diagnosis is intellectual disability. The record must show the tests performed, scoring and interpretation, as well as the time involved (time started and time ended). Billing should document the **total** time for face-to-face administration, scoring, interpretation and report writing. The test(s) given on the date of service billed must be documented in the treatment note for post payment review purposes. When scoring, interpreting and report writing for test(st) that were administered by a BHP or an AMHP, the documentation must include: the total time spent completing the report, the actual date(s) and names of the test(s) administered as well as the name of the BHP or AMHP who administered the test for the specified recipient in the treatment note for post payment review purposes. The units of measure for testing codes 96132/96133 has been changed from a 1 hour measurement increment to a 30 minute measurement increment, therefore when billing claims .5 units will equal 30 minutes; 1 unit will equal 1 hour; 1.5 units will equal 1 ½ hours, etc. Providers **cannot** bill less than a 30-minute increment. (*under daily max=combination of the codes)

   Each test performed must be medically necessary; therefore, standardized batteries of tests are not acceptable. Nonspecific behaviors that do not indicate the presence of, or change in, a mental illness would not be an acceptable indication for testing. Psychological or psychiatric evaluations that can be accomplished through the clinical interview alone would not require psychological testing and such testing might be considered medically unnecessary. A psychological technician with adequate training may directly provide services listed in the **Code of Alabama Governing Psychologists** Section 34-26-1 without supervision; the licensed psychologist must sign the report. A licensed psychologist must be on-site where an allied mental health professional is performing testing services within their scope of practice, and the licensed psychologist must sign the report.

8. Code 96146 describes psychological/ neuropsychological testing by a computer. CPT® code 96146 includes a single automated psychological or neuropsychological instrument that is administered via electronic platform (e.g. computer) and formulates in an automated result. Only report 96146 for a single test administered via electronic platform. Do not report 96146 for administration of 2 or more tests and/or if test administration is performed by professional or technician. This code is billed only **once** as one service regardless of the number of tests taken or time spent by the recipient completing the test. The computer code is

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used only when the recipient is taking a computer-based test unassisted. This code can only be billed if the computer is used to score tests.

9. These procedure codes may be used in any combination for no more than 52 units total annually. Procedure codes 90846, 90847, 90849 and 90853 may be billed on the same date of service as other codes listed in this group as per CPT® guidelines. For exceptional circumstances where more than 52 units will be needed, consideration for request must be submitted.
10. Procedure Code 96116 is intended to describe the performance of gathering information to provide an important first analysis of brain dysfunction and progression and changes in the symptoms over time. This exam must include screening for impairments in acquired knowledge, attention, language, learning, memory, planning and problem solving, and visual-spatial abilities. This code has been revised and should no longer be billed in multiple units.

    This service includes an initial interview to collect clinical information prior to evaluation and test administration and scoring services.

    - The first hour of the exam is billed with CPT® code 96116 and each additional hour needed to complete the exam is billed using code 96121.

    CPT® Time Rules allow an additional unit of a time-based code to be reported as long as the mid-point of the stated amount of time is passed. Beyond the first hour (96116), at least an additional 31 minutes of work must be performed to bill additional unit(s) of the add-on code 96121.

Testing Codes Crosswalk

2018 CPT® Descriptor (Previous Code)	2019 CPT® Descriptor (Replacement Codes)
96101	96130
	96131
	96136
	96137
96102	96130
	96131
	96138
	96139
96116	96116
	96121
96118	96132
	96133
	96136
	96137

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96119	96132
	96133
	96138
	96139
96103 and 96120	96146

NOTE:

Psychological Testing codes 96130, 96131, 96136, 96137, 96138, and 96139 can be billed in any combination for a max of 5 units annually. Neuropsychological Testing codes 96132, 96133, 96136, 96137, 96138, and 96139 can be billed in any combination for a max of 5 units annually.

11. For consideration of lifting the maximum cap on weekly unit limitations, submit a cover letter, documentation of medical necessity **and** the exceptional circumstance (*i.e. how the recipient is an eminent danger to self or others and/or is at risk for hospitalization or decompensation*) along with the claim, related progress note(s) and cover letter to the following address:

    Associate Director, Mental Health Programs
    P.O. Box 5624
    Montgomery, AL 36103-5624

    A sample Psychologist Override Request form (that can be used in lieu of a cover letter) can be found at:
    http://www.medicaid.alabama.gov/documents/9.0_Resources/9.4_Forms_Library/9.4.11_Mental_Health/9.4.11_Psychology_Override_Request_Template.pdf

12. Crisis Intervention is defined as immediate emergency intervention performed only by **the psychologist** 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.

    - 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

    1 unit=15 minutes; maximum billable units are 4 units per recipient per day; This code can also be performed (and reimbursed) for recipients with an Intellectual Disability, ICD-10 diagnosis codes (F070-F079).

13. "Billed on a weekly basis" means per calendar week (Sunday to Saturday).

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14. It is the responsibility of the provider to keep up with any and all updates and/or changes to CPT® and/or HCPCS ® codes applicable to billing.

Use of Modifiers

Codes billed by an LPC, ALC, LMFT, LMFTA, LICSW, LGSW, LPT or with an HO modifiers will be reimbursed at 75% of the allowable amount.

Modifier 59 (Distinct Procedural Service)

Under certain circumstances eligible psychologist (and/or allied professional mental health staff) staff may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier 59 is used to identify procedures/services that are not normally reported together, but are appropriate under the circumstances. This may represent a different session or patient encounter, not ordinarily encountered or performed on the same day by the same eligible psychologist (and/or allied professional mental health staff) staff. *However, when another already established modifier is appropriate, it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used.*

According to the CPT® book, modifier 59 is described as being necessary to describe a distinct procedural service. This modifier should only be used to show a distinct procedural service when a comprehensive/component coding pair is billed. Modifier 59 should not be billed to represent that multiple services of the same procedure code were performed.

A comprehensive/coding pair occurs when one code is considered a component procedure and the other code is considered a comprehensive procedure. These code pairs are frequently referred to as bundled codes thus meaning the component code is usually considered an integral part of the comprehensive code. Therefore, in most instances the most comprehensive code only should be billed and the component code should be denied as re-bundled or mutually exclusive.

Modifier 59 should only be used in conjunction with a comprehensive/ coding pair procedure when appropriately unbundling the code pair. This modifier 59 should not be billed with the comprehensive code. The component code can be unbundled or allowed separately, in certain situations. If the two services are performed at two different times of day, then modifier 59 can be submitted with the component procedure code.

In order to communicate the special circumstances of the component/ comprehensive code pair unbundling, diagnoses codes must be utilized as appropriate on the claim form. In some cases, it may be necessary to attach a detailed explanation of services rendered to further explain the reason for the unbundling of code pairs.

CMS publishes the National Correct Coding Initiative Coding Policy Manual for Medicare and Medicaid Services (https://www.medicaid.gov/medicaid/program-integrity/ncci/index.html) and this may be used as a reference for claims-processing edits. The manual is updated annually, and the NCCI edits are updated quarterly. It is the

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responsibility of the provider to check the site quarterly for any billing related updates.

NOTE:

Procedure codes 90862, pharmacologic management, and 90865, narcosynthesis for psychiatric diagnostic and therapeutic purposes, **are covered for physicians only** and may not be performed or billed by psychologists.

34.6.4 Place of Service Codes

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

POS Code	*Description*
03	School
11	Office
12	Home
21	Inpatient Hospital /(Psychologist Only)
22	Outpatient Hospital
23	Emergency Room – Hospital
31	Skilled Nursing Facility or Nursing Facility
32	Nursing Facility
51	Inpatient Psychiatric Facility (Psychologist Only)
52	Psychiatric Facility Partial Hospitalization
53	Community Mental Health Center
54	Intermediate Care Facility/Individuals With Intellectual Disabilities
55	Residential Substance Abuse Treatment Facility
56	Psychiatric Residential Treatment Center
72	Rural Health Clinic
99	Other Unlisted Facility

34.6.5 Required Attachments

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

- Claims With Third Party Denials

NOTE:

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

Refer to Section 5.8, Required Attachments, for more information on attachments.

34.7 Covered Services Eligible for Telemedicine

Refer to Chapter 112, Telemedicine Services, for general information and limitations.

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34.8 For More Information

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

Resource	Where to Find It
CMS-1500 Claim Filing Instructions	Chapter 5
Medical Medicaid/Medicare-related Claim Filing Instructions	Chapter 5
Medical Necessity/Medically Necessary Care	Chapter 7
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

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

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

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

National Provider Identifier, Type, and Specialty

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

NOTE:

The 10-digit NPI is required when filing a claim.

Renal Dialysis Facility providers are assigned a provider type of 30 (Renal Dialysis Facility). The valid specialty for Renal Dialysis Facility providers is Hemodialysis (300).

Enrollment Policy for Renal Dialysis Facility Providers

To participate in Medicaid, End Stage Renal Disease (ESRD) facilities/centers must meet the following requirements:

- Certification for participation in the Title XVIII Medicare Program
- Approval by the appropriate licensing authority

Satellites and sub-units of facilities or centers must be separately approved and contracted with Medicaid.

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Change of Ownership (CHOW) and Closures

Medicaid will mirror Medicare's Change of Ownership (CHOW) Policy
Refer to Chapter 19, Hospital for additional information on Change of Ownership

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. Refer to Chapter 7, Understanding Your Rights and Responsibilities as a Provider, for general criteria on Medical Necessity/ Medically Necessary Care.

Medicaid covers maintenance dialysis treatments when they are provided by a Medicaid-enrolled hospital-based renal dialysis center or a freestanding ESRD facility. The maintenance dialysis treatments do not count against the routine outpatient visit limit.

Hemodialysis is limited to 156 sessions per year, which provides three sessions per week.

Continuous Ambulatory Peritoneal Dialysis (CAPD) and Continuing Cycling Peritoneal Dialysis (CCPD) are furnished on a continuous basis, not in discrete sessions, and will be paid a daily rate, not on a per treatment basis. Providers are to report the number of days in the units field on the claim.

The daily IPD or CAPD/CCPD payment does not depend upon the number of exchanges of dialysate fluid per day (typically 3-5) or the actual number of days per week that the patient undergoes dialysis. The daily rate is based on the equivalency of one week of IPD or CAPD/CCPD to one week of hemodialysis, regardless of the actual number of dialysis days or exchanges in that week.

Reimbursement will be based on a composite rate consisting of the following elements of dialysis treatment:

- Overhead costs
- Personnel services, such as administrative services, registered nurse, licensed practical nurse, technician, social worker, and dietician
- Equipment and supplies
- Use of a dialysis machine
- Maintenance of the dialysis machine
- ESRD-related laboratory tests
- Biologicals and certain injectable drugs, such as heparin and its antidote

NOTE:

Dialysis facilities that have a physician who performs EKGs on-site can apply to enroll the physician with payment going to the facility. The CPT-4 procedure codes for EKG tracing and interpretation may be billed using the physician NPI on the CMS-1500 claim form.

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Laboratory Services

Laboratory tests listed below are considered routine and are included as part of the composite rate of reimbursement. When any of these tests are performed at a frequency greater than specified below, the additional tests are separately billable and are covered only if they are medically necessary and billed directly by the actual provider of the service. A diagnosis of ESRD alone is not sufficient medical evidence to warrant coverage of additional tests. The nature of the illness or injury (diagnosis, complaint, or symptom) requiring the performance of the test(s) must be present on the claim.

Hemodialysis

The following table lists Hemodialysis tests and frequency of coverage:

Frequency	*Covered Tests*
Per treatment	All hematocrit and clotting time tests furnished incidentally to dialysis treatments.
Weekly	Prothrombin time for patients on anticoagulant therapy; serum creatinine, BUN.
Monthly	Alkaline Phosphates LDH Serum Biocarbonate Serum Calcium Serum Chloride Serum Phosphorous Serum Potassium SGOT Total Protein

Continuous Ambulatory Peritoneal Dialysis (CAPD)

The following table lists CAPD tests and frequency of coverage.

Frequency	*Covered Tests*	
Monthly	BUN	Total Protein
	Creatinine	Albumin
	Sodium	Alkaline Phosphatose
	Potassium	LDH
	CO2	SGOT
	Calcium	HCT
	Magnesium	Hgb
	Phosphate	Dialysis Protein

All laboratory testing sites providing services to Medicaid recipients, either directly by provider or through contract, must be certified by Clinical Laboratory Improvement Amendments (CLIA) that they provide the required level of complexity for testing. Providers are responsible for assuring Medicaid that they strictly adhere to all CLIA regulations and for providing Medicaid waiver certification numbers as applicable.

Laboratories that do not meet CLIA certification standards are not eligible for reimbursement for laboratory services from Medicaid.

Ancillary Services

The actual provider of services must bill take home drugs that are medically necessary under the pharmacy program.

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Routine parenteral items are included in the facility composite rate and may not be billed separately.

Non-routine injectables administered by the facility may be billed by the facility actually providing this service. Non-routine injectables are defined as those given to improve an acute condition such as arrhythmia or infection.

Routine drugs or injectables administered in conjunction with dialysis procedures are included in the facility's composite rate and shall not be billed separately. These include but are not limited to the following:

- Heparin
- Glucose
- Protamine
- Dextrose
- Mannitol
- Antiarrythmics
- Saline
- Antihistamines
- Pressor drugs
- Antihypertensives
- Trace elements
- Multivitamins

The administration fee for injectables is included in the facility's composite rate and must not be billed separately under a physician NPI.

The following procedures are non-routine and must be billed by the actual provider of service:

Procedure Code	***Description/Limits***
76061	Bone Survey - annually (roentgenographic method or photon absorptrometric procedure for bone mineral analysis)
71020	Chest X-ray - every six months
95900	Nerve Conductor Velocity Test (Peroneal NCV) - every three months
93000	EKG - every three months

Intradialytic Parenteral Nutrition (IDPN) and Intraperitoneal Nutrition (IPN)

Requirements must be met and clearly documented in the medical record for coverage of IDPN and/or IPN. All services rendered are subject to post payment review.

The ordering physician will be responsible for writing a statement of medical necessity. This statement shall certify that the patient cannot be maintained on oral or enteral feedings and that due to severe pathology of the alimentary tract either hyper-alimentation or IDPN/IPN must be given for 100% of nutritional needs. The original signed statement of medical necessity must be kept in the patient’s medical record. This certification statement must be written or stamped on the prescription or reproduced on a form accompanying the prescription. The statement must be signed and dated by the certifying physician at the time of the initial order and updated yearly in accordance with Medicaid billing practice.

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IDPN and IPN involves infusing hyper-alimentation fluids as part of dialysis through the vascular shunt or intra-peritoneally to normalize the amounts of albumin, glucose, and other nutrients in the blood stream to decrease morbidity and mortality associated with protein calorie malnutrition. IDPN and IPN solutions are considered **not covered** for the recipient with a functioning gastrointestinal tract whose need for parenteral nutrition is only due to the following:

- If IDPN or IPN is offered as an addition to regularly scheduled infusions of TPN
- If the recipient would not qualify as a candidate for TPN
- A swallowing disorder
- A temporary defect in gastric emptying such as a metabolic or electrolyte disorder
- A psychological disorder, such as depression, impairing food intake
- A metabolic disorder inducing anorexia, such as cancer
- A physical disorder impairing food intake, such as dyspnea or severe pulmonary or cardiac disease
- A side effect of medication
- Renal failure and/or dialysis

The following requirements must be met in order to bill for IDPN or IPN solutions:

- Documentation in the medical record must validate the patient suffers from a permanently impaired gastrointestinal tract and that there is insufficient absorption of nutrients to maintain adequate strength and weight.
- Documentation must include that the patient cannot be maintained on oral or enteral feedings and that due to severe pathology of the alimentary tract, IDPN or IPN must be given in order to meet 100% of the patient's nutritional needs.
- Infusions must be vital to the nutritional status of the recipient and not supplemental to a deficient diet or deficiencies caused by dialysis.
- Physical signs, symptoms and test results indicating severe pathology of the alimentary tract must be clearly documented in the medical record. This would include, but is not limited to; creatinine (predialysis), serum albumin (predialysis), a low or declining serum cholesterol and phosphorus. Medical records must document inability to maintain weight during a trial of at least four weeks of enteral feeding.

A few solutions used in TPN preparation are considered payable as part of the composite rate for dialysis and should not be billed separately by the pharmacist. These are glucose, dextrose, trace elements and multivitamins.

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EPO and Aranasp Monitoring Policy

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

GS	Dosage of EPO or Darbopoetin Alfa has been reduced and maintained in response to hematocrit or hemoglobin level.
ED	The hematocrit level has exceeded 39.0% (or hemoglobin 1evel has exceeded 13.0g/dL) 3 or more consecutive billing cycles immediately prior to and including the current billing cycle
EE	The hematocrit level has exceeded 39.0% (or hemoglobin level has exceeded 13.0g/dL) less than 3 consecutive billing cycles immediately prior to and including the current billing cycle.

Physician Services

Physician services rendered to each outpatient maintenance dialysis patient provided during a full month shall be billed on a monthly capitation basis using the appropriate procedure code by age as outlined in the CPT. Monthly maintenance dialysis payment (i.e., uninterrupted maintenance dialysis) is comprehensive and covers most of a physician's services whether a patient dialyzes at home or in an approved ESRD outpatient facility. Dialysis procedures are allowed in addition to the monthly maintenance dialysis payment. In general, the Agency follows Medicare guidelines related to monthly capitation payments for physicians.

Physician services included in the monthly capitation payment for ESRD related services include, but are not limited to:

- Assessment and determination of the need for outpatient chronic dialysis therapy
- Assessment and determination of the type of dialysis access and dialyzing cycle,
- Management of the dialysis visits including outpatient visits for evaluation and management, management during the dialysis, and telephone calls.
- Assessment and determination if a recipient meets preliminary criteria as a renal transplant candidate including discussions with family members
- Assessment for a specified diet and nutritional supplementation for the control of chronic renal failure, including specifying quantity of total protein, sodium, potassium, amount of fluids, types of anemia and appropriate treatments, type of arthropathy or neuropathy and appropriate treatment or referral, estimated ideal dry weight, etc. Assessment for diabetic patient's diet and caloric intake is included also.

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- Prescribing the parameters of intradialytic management including anticoagulant, dialysis blood flow rates and temperature, duration and frequency of treatments, etc.

The monthly capitation payment is limited to once per month, per recipient, per provider.

The following services are not covered by the monthly capitation payment (MCP) for the attending dialysis physicians and are reimbursed in accordance with usual and customary charge rules:

- Declotting of shunts
- Covered physician services furnished to hospital inpatients by a physician who elects not to receive the MCP for these service, For example, an attending physician who provides evaluation and management (E&M) services for a renal patient in an inpatient setting may bill appropriate CPT hemodialysis procedures in lieu of certain other E&M services for inpatient visits.
- Nonrenal related physician services furnished by the physician providing renal care or by another physician. (These services may not be incidental to services furnished during a dialysis session or office visit necessitated by the renal condition.) For example, physician services rendered to hospitalized inpatient recipients who require dialysis but are not receiving dialysis on that day may use the appropriate procedure code as described in the CPT.

Physician services are allowed for outpatient maintenance dialysis patients not performed as prescribed during a full month or interruptedly. An example of interrupted monthly outpatient dialysis maintenance is preceding and/or following the period of hospitalization.

The CPT codes described by age for physicians rendering outpatient dialysis services that are interrupted during a full month should be billed on a per day basis. These codes should be billed for the days of the month in which the outpatient ESRD related services were performed.

Single or repeated physician assessments are allowed for hemodialysis or dialysis procedures other than hemodialysis. These services are comprehensive and include assessment and management related to the patient's renal dialysis. Please utilize the most descriptive and appropriate CPT dialysis procedure when billing for single or repeated physician evaluation(s).

Dialysis training is a covered service when billed by an approved ESRD facility.

35.3 Prior Authorization and Referral Requirements

Dialysis procedure codes generally do not require prior authorization. Any service that is warranted outside of these codes must have prior authorization. Refer to Chapter 4, Obtaining Prior Authorization, for general guidelines.

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When filing claims for recipients enrolled in the Alabama Coordinated Health Network (ACHN) Program, refer to Chapter 40, to determine whether your services require a referral from the Primary Care Physician (PCP).

35.4 Cost Sharing (Copayment)

Copayment does not apply to services provided by Renal Dialysis Facility providers.

35.5 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

Renal Dialysis Facility providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When filing a claim on paper, a UB-04 claim form is required. Medicare-related claims must be filed using the Institutional Medicaid/Medicare-related Claim Form.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

35.5.1 Time Limit for Filing Claims

Medicaid requires all claims for Renal Dialysis Facilities to be filed within one year of the date of service. Refer to Section 5.1.5, Filing Limits, for more information regarding timely filing limits and exceptions.

35.5.2 Diagnosis Codes

The *International Classification of Diseases - 10th Revision - Clinical Modification* (ICD-10-CM) manual lists Medicaid required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, AMA Plaza 330 North Wabash Ave, Suite 39300 Chicago, IL 60611-5885, or 1-800-621-8335.

NOTE:

ICD-9 codes should be used for claims submitted with dates of service prior to or equal to 09/30/2015.

ICD-10 codes should be used for claims submitted with dates of service on/after 10/01/2015.

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NOTE:

ICD-9 or ICD-10 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

35.5.3 Procedure Codes, Revenue Codes, and Modifiers

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

Revenue Codes	Condition Codes	Procedure Code	Description
821, 881	71, 72,73, 74, 76	90999	Hemodialysis, home hemodialysis, self-care training, home hemo training and ultrafiltration.
831, 841, 851	74	90945	Dialysis procedure other than hemodialysis
831, 841, 851	73	90993	Dialysis training, patient, including helper.
634,<10,000 635, >or = 10,000		Q4081	Injection epogen
636		J0882	Darbopoetin alfa, injection
636		Appropriate Injectable Codes	Injectable Drugs
250		Appropriate NDC Codes (No HCPCS)	PO Drugs
31X, 921		Appropriate Lab Codes	Labs
270		A4657, A4913 (IV)	Supply/Admin
771		Appropriate vaccine HCPCS	Vaccine

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

Revenue Codes	Condition Codes	Procedure Code	Description
821	71	90999	Hemodialysis, limited to 156 units per year.
831, 841, 851		90945	Dialysis procedure other than hemodialysis.

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Revenue Codes	Condition Codes	Procedure Code	Description
831, 841, 851	73, 74	90993	Dialysis training, patient, including helper. Limited to 12 per lifetime.
634,<10,000 635, >or = 10,000		Q4081	Injection epogen
636		J0882	Darbopoetin alfa, injection
636		Injectable Codes	See Alabama Medicaid website www.medicaid.alabama.gov for the Injectable Drug Listing.

35.5.4 Place of Service Codes

Place of service codes do not apply when filing the UB-04 claim form.

35.5.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to claims with third party denials.

NOTE:

When an attachment is required, a hard copy UB-04 claim form must be submitted.

Refer to Section 5.8, Required Attachments, for more information on attachments.

35.6 For More Information

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

Resource	Where to Find It
UB-04 Claim Filing Instructions	Chapter 5
Medical Medicaid/Medicare-related Claim Filing Instructions	Chapter 5
Medical Necessity/Medically Necessary Care	Chapter 7
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 (IRHC) are physician-owned. These clinics are reimbursed at the reasonable cost rate per visit (encounter) established for the clinic by Medicaid.

Reimbursement for an enrolled out-of-state IRHC will be the lesser of the encounter rate established by the Medicaid Department of the out-of-state IRHC or the average encounter rate established by Alabama Medicaid for in-state facilities.

Refer to the *Alabama Medicaid Agency Administrative Code,* Chapter 8, for policy provisions for independent rural health clinic providers

36.1 Enrollment

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

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

National Provider Identifier, Type, and Specialty

A provider who contracts with Medicaid as a rural health clinic provider is added to the Medicaid system with the National Provider Identifiers provided at the time application is made. Appropriate provider specialty codes are assigned to enable the provider to submit requests and receive reimbursements for claims. The 10-digit NPI is required when filing a claim.

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

Rural health clinics are assigned a provider type of 58 and specialty of 081.

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Physicians affiliated with rural health clinics are enrolled with a NPI, which links them to the clinic. The provider type for the physician is 58 (Rural Health Clinic). The valid specialties are any of those specialties valid for physicians. Please refer to Chapter 28, Physician, for a listing of valid specialties.

All other personnel affiliated with the rural health clinic, such as physician assistants or nurse practitioners, bill using the clinic's NPI, and are not assigned individual NPIs.

Enrollment Policy for Independent Rural Health Clinics

To participate in the Alabama Medicaid Program, independent rural health clinic (IRHC) providers must meet the following requirements:

- Submit a copy of the following documentation of Medicare certification: the Centers for Medicare and Medicaid Services (CMS) letter assigning the NPI.
- Submit a copy of the clinics budgeted cost report to Medicaid Alternative Services program to establish the reimbursement rate.
- Submit a copy of the CMS Clinical Laboratory Improvement Amendments of 1988 (CLIA) certificate or waiver.
- Operate in accordance with applicable federal, state, and local laws.

The effective date of enrollment of an independent rural health clinic will be the date of Medicare certification. However, if a provider's request for enrollment is received more than 120 days after the date of their Medicare certification, then the effective date will be the first day of the month the enrollment is initially received by Medicaid's Fiscal Agent.

Change of Ownership (CHOW) and Closures

Medicaid will mirror Medicare's Change of Ownership (CHOW) policy. Refer to Chapter 19, Hospital for additional information on Change of Ownership.

The new owner may choose to accept the established reimbursement rate or submit a budgeted cost report to the Medicaid Agency and must submit his choice in writing to Medicaid's Provider Audit Program within 30 days of the change of ownership.

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. Refer to Chapter 7, Understanding Your Rights and Responsibilities as a Provider, for general criteria on Medical Necessity/ Medically Necessary Care.

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.

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Independent rural health clinic services are reimbursable if they are provided by any of the following individuals:

- Physician
- Physician assistant, nurse practitioner, certified nurse midwife, registered nurse, or clinical social worker as an incident to a physician's service

The physician, physician assistant, nurse practitioner, certified nurse midwife, registered nurse or clinical social worker must conform to all state requirements regarding the scope or conditions of their practice.

The CRNP can make physician-required visits to nursing facilities. However, a CRNP cannot make physician required inpatient visits to hospitals or other institutional settings to qualify for payment to the physician or to satisfy current regulations as physician visits. The PA or CRNP may provide low complexity or straightforward medical decision-making services in the emergency department for Medicaid reimbursement.

A nurse practitioner, physician assistant, or certified nurse midwife must be available to furnish patient care at least fifty (50%) percent of the time the clinic operates

The Independent Rural Health Clinic must be under the medical direction of a physician. Except in extraordinary circumstances, the physician must be physically present for sufficient periods of times, at least every 72 hours for non-remote sites and every seven (7) days for remote sites (a remote site being defined as a site more than 30 miles away from the primary supervising physician's principal practice location), to provide medical care services, consultation, and supervision in accordance with Medicare regulations for Rural Health Clinics. When not physically present, the physician must be available through direct telecommunication for consultation, assistance with medical emergencies, or patient referral. The extraordinary circumstances must be documented in the records of the clinic.

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.

36.2.2 Reimbursement

IRHC services are reimbursed by an all-inclusive encounter rate. All services provided for that date of service will be included in the encounter rate. If a recipient only has lab or x-rays, this will also constitute an encounter.

Encounters are face-to-face contacts between a patient and a health professional for medically necessary services.

Surgical procedures performed in place of service 21 (inpatient) or place of service 22 (outpatient) will be reimbursed fee-for-service.

Contacts with one or more health professionals and multiple contacts with the same health care professional that take place on the same day at a single location constitute a single encounter unless the patient later suffers illness or injury requiring additional diagnosis or treatment.

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Reimbursement for an enrolled out-of-state IRHC will be the lesser of the encounter rate established by the Medicaid Department of the out-of-state IRHC or the average encounter rate established by Alabama Medicaid for in-state facilities.

As described in Section 1902(aa) of the Social Security Act, IRHCs will be paid under a prospective payment system rate (PPS rate) effective January 1, 2001. The rate setting period is from October 1 through September 30th. Each IRHC is entitled to the payment amount (on a per visit basis) to which the IRHC was entitled to in the previous fiscal year, increased by the percentage increase in the Medicare Economic Index (MEI) for primary care services, and adjusted to take into account any increase (or decrease) in the scope of services furnished by the IRHC during that fiscal year.

If a service has been eliminated, the Health Center must notify Medicaid that they have discontinued a given service. Medicaid must be notified in writing within ninety (90) calendar days of any termination of service(s). The notification of discontinued service must include the 12-month cost report for the discontinued service leading up to the termination of the service. The Agency may request additional documentation. This decrease in the scope of services furnished will result in a recalculation of the PPS rate. Failure to notify Medicaid of a termination of service may result in recoupment of paid claims.

Deleted: ~~This decrease in…the PPS rate.~~
Added: An elimination of…impact of 3%.

IRHC services and other ambulatory services provided at the IRHC will be reimbursed by an all-inclusive encounter rate. Refer to the *Alabama Medicaid Agency Administrative Code*, Chapter 56, for details.

Deleted: ~~NOTE: A deletion in…CIS submission limitation.~~

Change in Scope (CIS)

Deleted: ~~Reimbursement for all…for in-state facilities~~

An IRHC may request that their PPS rate be adjusted to take into account a change (either increase or decrease) in the scope of services furnished by the IRHC. A change in scope of services is defined as a change in the type, intensity, duration, and/or amount of services provided during a IRHC visit. Change in Scope requests must meet regulatory compliance as required by state and federal law as it relates to the operation of IRHC services provided under the Alabama Medicaid ("Medicaid") Program.

A change in scope request must be sent to the Managed Care Operations Division for review. The request must specifically state what IRHC service was changed, and specifically detail how the type, intensity, duration, or amount of that service has changed. Medicaid will not review the CIS request until a complete submission is received. A complete submission includes the documentation listed below. The CIS request must be submitted to the Agency no later than 180 days (six months) after the Health Clinic's fiscal year end. The request shall include, at a minimum, the following items clearly labeled and identified documentation:

Added: Medicaid will not…documentation listed below
Deleted" ~~should~~
Added: must
Deleted: ~~ninety (90)~~
Added: 180
Added: (six months)
Deleted: ~~twelve (12) months of CIS activity~~
Added: the Health Clinic's fiscal year end
Added: items clearly labeled and identified

1. Narrative of the Qualifying Event or Events including a description of the Event or Events and other relevant information such as the locations affected, the date new services began, time period over which the changes took place or how patients are impacted; any relevant supporting documentation should also be provided. The Health Clinic must specify their fiscal year period in the narrative that will be submitted with the CIS request. Failure to disclose the fiscal year in the narrative will result in an incomplete submission.

Added: The Health Clinic…an incomplete submission.

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2. A CIS Medicaid cost report with at least 12-months of actual expenses associated with the requested change in scope
    - The Medicaid cost report must reflect ALL clinic visits. Also, initial supporting documentation must include the following:
        - General Ledger Detail (in excel format) for the period under audit
        - Trial Balance (in excel format)
        - Crosswalk of Trial Balance accounts to Medicaid cost report line item
        - Medicare Cost Report for period(s) consistent with the Medicaid Cost Report
3. The IRHC's proposed PPS rate with detailed documentation of how the proposed PPS rate was derived or calculated.
4. A listing of deleted services not reported to Medicaid, if applicable. Listing must include the deleted service and the date the service was deleted.

Added: Medicare Cost Report…Medicaid Cost Report

Deleted: ~~Other documentation as…by the Agency.~~

The Medicaid Agency may request more documentation or clarification of the documentation provided. If the IRHC fails or refuses to provide the documentation requested by the Medicaid Agency, the change in scope request may be denied. IRHCs may submit one CIS request within 12-months of the last submitted CIS request.

Deleted: ~~IRHCs shall only…state fiscal year.~~
Added: IRHCs may submit…services that an

NOTE:

A deletion in service(s) does not count towards the 12-month CIS submission limitation.

The Agency will notify the Health Clinic within seven days of receipt of a CIS request. If the Health Clinic does not receive a response within seven days, it is the Health Clinic's responsibility to reach out to the Agency regarding receipt of the CIS request. The Agency will review the CIS request to determine if the CIS request is complete. The Agency will notify the Health Clinic within 30 days regarding the completion status of the CIS request. The Agency will notify the Health Clinic within 60 days from CIS submission completion date of the approved qualifying events.
A change in the scope of service occurs if the IRHC has added or discontinued any service that meets the definition of IRHC services as provided in Section 1905(a) (2) (B) and (C) of the Act, ***and*** the service is included as a covered Medicaid service under the Alabama Medicaid State Plan. A change in the scope of service is defined as a change in the type, intensity, duration and/or amount of services compared to the services offered at the time of the last change of scope rate adjustment.

Type- the FQHC/RHC has added or dropped any service that meets the definition of FQHC/RHC services as provided in section 1905(a) (2) (B) and (C) of the Social Security Act or if the service is included as a covered Medicaid service in the State Plan.

Intensity- a change in the characteristics of services offered in an average visit such that the average patient receives a different array of services.

Amount- an increase or decrease in the quantity of services that an

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Added: average patient receives…to changing circumstances.

average patient receives in an average visit.

Duration- a change in the average length of time it takes medical providers to complete an average patient visit due to changing circumstances.

Deleted: ~~The change in…amount, or duration.~~

A change in scope review will not take increased costs or inflation into account. Further, Patient-Centered Medical Home (PCMH) certification will not qualify for a rate adjustment. When the cost of the changed service has been determined, the incremental/decremental rate adjustment to the individual service will be combined into the overall PPS rate thereby calculating a revised encounter rate. Only the services that changed will be included in the PPS rate calculation during the change in scope request review. If the new PPS rate results in an overall increase or decrease of at least 3 percent of the PPS rate at the time Medicaid receives the change in scope request, then the PPS rate will be adjusted. The effective date of the new PPS rate will be the first day of the month that the Medicaid Agency receives a completed CIS request. The Agency will notify the health clinic within 30 days if the CIS request is complete or not. A complete submission includes the documentation listed above.

Deleted: ~~The new PPS…final rate determination.~~
Added: The effective date…be May 1st.

NOTE:

For example: if a CIS request is received on March 31, but does not contain all required information, it will be returned. On May 15th, the Agency receives the resubmitted CIS request with all required documentation, therefore the effective date will be May 1st.

The IRHC must demonstrate the following:

- a cost impact per qualifying event or a combination of more than one qualifying event and
- the incremental cost impact per visit to the change in scope of service.

Deleted: ~~60- Provider Based Rural Health Clinic Reimbursement~~
Added: 56

Any costs supporting the rate adjustment must be allowable for IRHCs under the Administrative Code Chapter 56. The calculated incremental cost per visit of the change in scope will be applied to the PPS rate currently in effect.

A Change in Scope request may take more than a period of one year to process; however, the Agency anticipates processing change in scope requests within 6 months. For additional information, please contact the Managed Care Operations Division.

NOTE:

New PPS rates due to an approved change in scope will be based on the incremental and/or decremental costs of the approved qualifying event(s).

Family Planning

- Family planning services are services provided to prevent or delay pregnancy.

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- Intrauterine Devises are billable and reimbursable outside of the encounter rate utilizing the non-IRHC National Provider Identifier (NPI) and on a separate claim.
- The Plan First visit will be reimbursed at the encounter rate when billed.
- For additional information, see Medicaid's Provider Manual Appendix C.

Smoking cessation products (under Family Planning) are billable and reimbursable outside of the encounter rate utilizing the non-IRHC National Provider Identifier (NPI) and on a separate claim.

Deliveries are billable and reimbursable outside of the encounter rate utilizing the non-IRHC National Provider Identifier (NPI) and on a separate claim.

Services are billable and reimbursable outside of the encounter rate under the non-IRHC National Provider Identifier (NPI) and on a separate claim include:

- Surgeries with place of service code 21 or 22
- Technical component for: Electrocardiograms (EKG's) and Radiology

1st Look- The Oral Health Risk Assessment and Dental Varnishing Program

For IRHCs reimbursement for these services will be included in the office visit and will not be paid separately.

For additional Oral Health Risk Assessment and Dental Varnishing information and guidelines please refer to Medicaid's Provider Manual Dental Chapter 13and Appendix A.

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 Alabama Coordinated Health Network (ACHN) Program, refer to Chapter 40, to determine whether your services require a referral from the Primary Care Physician (PCP).

36.4 Cost Sharing (Copayment)

The copayment amount $3.90 per visit including crossovers. The copayment does not apply to services provided for pregnant women, nursing facility residents, recipients less than 18 years of age, emergencies, and family planning. Native American Indians that present an "active user letter" issued by Indian health Services (IHS) will be exempt from the Medicaid required copayment.

Providers may not deny services to any eligible Medicaid recipient because of the recipient's inability to pay the cost-sharing (copayment) amount imposed.

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NOTE:

Medicaid copayment is NOT a third party resource. Does not record copayment on the CMS-1500 claim form.

Medicare Deductible and Coinsurance

For independent rural health clinic services, Medicaid pays the Medicare deductible and coinsurance up to the encounter rate, established by Medicaid. Please refer to Chapter 5, Filing Claims, for additional information.

36.5 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

Independent rural health clinics that bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When filing a claim on paper, a CMS-1500 claim form is required. Medicare-related claims must be filed using the Medical Medicaid/Medicare-related Claim Form.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

36.5.1 Time Limit for Filing Claims

Medicaid requires all claims for independent rural health clinics to be filed within one year of the date of service. Refer to Section 5.1.5, Filing Limits, for more information regarding timely filing limits and exceptions.

36.5.2 Diagnosis Codes

The *International Classification of Diseases - 10th Revision - Clinical Modification* (ICD-10-CM) manual lists required diagnosis codes.

NOTE:

ICD-9 codes should be used for claims submitted with dates of service prior to or equal to 09/30/2015.

ICD-10 codes should be used for claims submitted with dates of service on/after 10/01/2015.

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NOTE:

ICD-9 or ICD-10 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

36.5.3 Procedure Codes and Modifiers

Medicaid uses the Healthcare Common Procedure Coding System (HCPCS). HCPCS is composed of the following:

- American Medical Association's Current Procedural Terminology (CPT)
- Nationally assigned codes developed for Medicare
- Locally assigned codes issued by Medicaid. Effective for dates of service on or after 01/01/2004, use national codes.

The CPT manual lists most procedure codes required by Medicaid.

Refer to Appendix H, Alabama Medicaid Injectable Drug Listing.

Claims without procedure codes or with codes that are invalid will be denied. Medicaid recognizes modifiers when applicable. Both CPT and CMS level codes will be recognized. The (837) Professional, Institutional and Dental electronic claims and the paper claims have been modified to accept up to four Procedure Code Modifiers.

Collection of laboratory specimens may be billed when sending specimens to another site for analysis if the other site is not owned, operated, or financially associated with the site in which the specimen was collected.

The collection fee may not be billed if the lab work is done at the same site where the specimen was collected or in a lab owned, operated, or financially associated with the site in which the specimen was collected.

Providers will not be paid for and should not submit claims for laboratory work done for them by independent laboratories or by hospital laboratories.

Providers may submit claims for laboratory work done by them in their own offices or own laboratory facilities. Providers who send specimens to independent laboratories for analysis may bill a collection fee. This fee shall not be paid to any provider who has not actually extracted the specimen from the patient.

Providers should use procedure code 36415-90 for routine venipuncture collection, 36416-90 for collection for capillary blood specimen (eg, finger, heel, ear stick) and Q0091-90 for collection of Pap smear specimen.

Labs are billable and reimbursable outside of the encounter rate utilizing the non-IRHC National Provider Identifier (NPI) and on a separate claim.

Encounters are all-inclusive. All services provided for the encounter are included in the reimbursement rate for the encounter.

Encounters are face-to-face contacts between a patient and a health professional for medically necessary services.

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Contacts with one or more health professionals and multiple contacts with the same health care professional that take place on the same day at a single location constitute a single encounter, unless the patient later suffers illness or injury requiring additional diagnosis or treatment.

To receive the IRHC encounter rate:

- Itemize the billing services performed
- Utilize the Current Procedure Terminology (CPT) Code Book
- Document medical support in the recipient chart to justify level of care billed
- Submit a clean claim (refer to Provider Manual Chapter 5)
- Utilize the IRHC National Provider Identifier (NPI)

Early and Periodic Screening, Diagnostic and Treatment (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. See Appendix A in Medicaid's Provider Manual for additional information.

EPSDT Vision Screenings, Hearing Screens, Cognitive Screenings, and Behavioral Assessments are reimbursable utilizing the IRHC National Provider Identifier (NPI). Claims that are billed using the non-IRHC number for reimbursement will be monitored on a post payment review process. Claims that are filed and paid with these procedures outside of the encounter rate will be subject to recoupment.

Vaccines For Children (VFC)

- Refer to Appendix A, EPSDT, for procedure codes for VFC.
- Vaccines are reimbursable outside of the encounter rate utilizing the IRHC National Provider Identifier (NPI) and on a separate claim.

36.5.4 Place of Service Codes

The following place of service codes apply when filing claims for independent rural health clinics:

POS Code	*Description*
11	Office
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room – Hospital
31	Skilled Nursing Facility or Nursing Facility
32	Nursing Facility

36.5.5 Required Attachments

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

- Claims with Third Party Denials

Refer to Section 5.8, Required Attachments, for more information on attachments.

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36.6 For More Information

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

Resource	Where to Find It
CMS-1500 Claim Filing Instructions	Chapter 5
Medical Medicaid/Medicare-related Claim Filing Instructions	Chapter 5
Medical Necessity/Medically Necessary Care	Chapter 7
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, Speech, and Applied Behavior Analysis)

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 an EPSDT Referral form (Form 362) as a result of an abnormality discovered during the EPSDT exam
- Provider treats QMB recipients

Physical therapy is 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 EPSDT referred therapy providers can be found in the *Alabama Medicaid Agency Administrative Code,* Chapter 11.

37.1 Enrollment

Alabama Medicaid's Fiscal Agent enrolls therapy providers and issues provider contracts to applicants who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative C*ode, and the *Alabama Medicaid Provider Manual*.

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

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

National Provider Identifier, Type, and Specialty

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

NOTE:
The 10-digit NPI is required when filing a claim.

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Therapy providers are assigned a provider type of 17 (Therapy). Valid specialties for therapy providers include the following:

- Occupational Therapy (171)
- Physical Therapy (170)
- Speech Therapy (173)
- Applied Behavior Analysis (ABA) Therapy (175)

Therapists may enroll independently and have their own NPI bill on a CMS-1500 claim form as an EPSDT/QMB-only provider. Refer to Chapter 19, Hospital, for billing information for therapists enrolled by a hospital.

Enrollment Policy for Therapy Providers

Services provided must be ordered by a physician or a non-physician practitioner for an identified condition(s) noted during the EPSDT screening and provided by or under:

- For physical therapy services, a qualified physical therapist
- For occupational therapy (OT) services, the direct supervision of a qualified occupational therapist
- For speech and language services, a qualified speech - language pathologist
- For applied behavior analysis services, a licensed behavior analyst, licensed psychologist or licensed psychiatrist with behavior analysis within their scope of practice

A qualified Speech Therapist must have a Certification of Clinical Competence in Speech Language Pathology or be eligible for certification and licensed by the Alabama Board of Examiners for Speech, Language Pathology, and Audiology.

A qualified occupational therapist must be licensed by the Alabama State Board of Occupational Therapy.

A qualified physical therapist must be licensed by the Alabama Board of Physical Therapy.

A qualified behavior analyst must be licensed by the Alabama Behavior Analyst Licensing Board.

A licensed psychologist or psychiatrist may request to add the ABA therapy specialty – 175 to their enrollment.

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. Refer to Chapter 7, Understanding Your Rights and Responsibilities as a Provider, for general criteria on Medical Necessity/ Medically Necessary Care.

Services provided to Medicaid-eligible children by those working under the direction of licensed, enrolled speech therapists, occupational therapists, physical therapists or behavior analysts are subject to the following conditions:

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- The person providing the service must meet the minimum qualifications established by state laws and Medicaid regulations.
- A supervising provider must employ the person providing the service.
- The case record must identify the person providing the service.
- The supervising therapist must assume full professional responsibility for services provided and bill for such services.
- The supervising provider must assure that services are medically necessary and are rendered in a medically appropriate manner.
- Services must be ordered by a physician or a non-physician practitioner.

For more information about the Plan of Treatment (plan of care, treatment plan, etc.) required for therapy services, refer to Chapter 19.

Speech Therapists (ST-Speech Language Pathologists)

Speech therapy services must be provided by or under the direct supervision of a qualified speech therapist. Services are limited to those procedure codes identified in Section 37.5.3, Procedure Codes and Modifiers.

Speech therapy assistants must be employed by a speech therapist, have a bachelor's degree in Speech Pathology, and be registered by the Alabama Board of Speech, Language Pathology, and Audiology. Assistants are only allowed to provide services commensurate with their education, training, and experience. They may not evaluate speech, language, or hearing; interpret measurements of speech language or hearing; make recommendations regarding programming and hearing aid selection; counsel patients; or sign test reports or other documentation regarding the practice of speech pathology. Assistants must work under the direct supervision of a licensed speech pathologist.

Direct supervision requires the physical presence of the licensed speech pathologist in the same facility at all time when the assistant is performing assigned clinical responsibilities. The licensed speech pathologist must document direct observation of at least 10% of all clinical services provided by the assistant. Speech therapists may supervise no more than the equivalent of two full-time assistants concurrently.

NOTE:

Speech therapy services must be ordered by a physician and must be provided by or under the direct supervision of a qualified speech therapist.

Occupational Therapists (OT)

Occupational therapy services must be provided by or under the direct supervision of a qualified occupational therapist.

Services are limited to those procedures identified in Section 37.5.3, Procedure Codes and Modifiers. Some codes may require prior authorization before services are rendered. Medicaid does not cover recreational activities, such as movies, bowling, or skating.

Occupational therapy assistants may assist in the practice of occupational therapy only under the supervision of an OT. Occupational therapy assistants a license by the Alabama State Board of Occupational Therapy (ASBOT).

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Supervision of OT assistants must comply with regulations of the ASBOT. The occupational therapist must render the hands – on treatment, write, and sign the treatment note at a minimum of every 6th visit or 90 days. When making a visit the supervising OT must document and sign notes regarding the visit. . The supervising OT assign the duties and responsibilities for which the assistant has been specifically educated and form.

Occupational therapy aides employed by the OT may perform only routine duties under the direct, on-site supervision of the OT with no charge for occupational.

Physical Therapists (PT)

Physical therapy assistants may provide service only under the supervision of a qualified physical therapist. PT assistants requires a license by the Alabama Board of Physical Therapy, and must be an employee of the supervising PT. The PT assistant must only be assigned duties and responsibilities for which the assistant has been specifically educated and which the assistant is qualified to perform.

Licensed certified physical therapist assistants (PTA) are covered providers when working under the direction of a Preferred Physical Therapist with the following provisions:

- The Physical Therapist must interpret the physician's referral.
- The Physical Therapist must perform the initial evaluation.
- The Physical Therapist must develop the treatment plan and program, including long and short-term goals.
- The Physical Therapist must identify and document precautions, special problems, contraindications, goals, anticipated progress and plans for reevaluation.
- The Physical Therapist must reevaluate the patient and adjust the treatment plan, perform the final evaluation and discharge planning.
- The Physical Therapist must implement (perform the first treatment) and supervise the treatment program
- The Physical Therapist must co-sign each treatment note written by the PTA.
- The Physical Therapist must indicate he/she has directed the care of the patient and agrees with the documentation as written by the PTA for each treatment note.

Long Term Therapy Services:

Therapeutic goals must meet at least one of the following characteristics:

- prevent deterioration and sustain function;
- provide interventions that enable the beneficiary to live at their highest level of independence in the case of a chronic or progressive disability;
- and/or provide treatment interventions for a beneficiary who is progressing, but not at a rate comparable to the expectations of restorative care.

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Maintenance Services:

- A repetitive service that does not require the knowledge or expertise of a qualified practitioner and that does not meet the therapy services. Maintenance services begin with the achievement of the therapeutic goals of a treatment plan or when no additional medical benefit is apparent or expected.

The Physical Therapist must render the hands-on treatment, write and sign the treatment note at a minimum of every sixth visit.

According to practice guidelines and state/federal law, written orders must include the date and signature of the provider, the service(s) ordered and the recipient's name. The EPSDT referral form is the physicians' order when meeting these guidelines.

NOTE:

To determine if a procedure code requires prior authorization, use the Automated Voice Response System (AVRS).

Applied Behavior Analysts (ABA Therapists)

Behavior Analyst services must be provided by or under the direct supervision of a qualified behavior analyst, psychologist, or psychiatrist. Services are limited to those procedure codes identified in Section 37.5.3, Procedure Codes and Modifiers.

Applied Behavior Analysis services are covered when provided by a Licensed Behavior Analyst (BCBA), a Licensed Assistant Behavior Analyst (BCaBA) under the supervision of a BCBA, or by an unlicensed Registered Behavior Technician (RBT) under the supervision of a BCBA or BCaBA within the scope of their practice as defined by state law. Providers must follow the current Behavior Analyst Certification Board® credentialing requirements. The BCBA and BCaBA must in good standing with the State of Alabama.

BCaBAs and RBTs must be employed by a BCBA and the BCBA assumes professional responsibility for the services provided by an unlicensed RBT or a BCaBA. Claims must be submitted by the BCBA. The BCBA and BCaBA must document supervision and direct observation according to the current requirements of the Behavior Analyst Certification Board® for clinical services provided by a BCaBA or RBT.

Locum Tenens and Substitute Physical/Occupational Therapist Under Reciprocal Billing Arrangements

It is common practice for physical/occupational therapists to retain substitute physical/occupational therapists to take over their professional practices when the regular physical/occupational therapists are absent for reasons such as illness, pregnancy, vacation, or continuing medical education, and for the regular physical therapist to bill and receive payment for the substitute physical/occupational therapists services as though he/she performed them. The substitute physical/occupational therapist generally has no practice of his/her own and moves from area to area as needed. The regular physical/occupational therapist generally pays the substitute physical/occupational therapist a fixed amount per diem, with the substitute

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physical/occupational therapist having the status of an independent contractor rather than of an employee. The substitute physical/occupational therapists are generally called “locum tenens” physical/occupational therapists.

Reimbursement may be made to a physical/occupational therapist submitting a claim for services furnished by another physical/occupational therapist in the event there is a reciprocal arrangement. The reciprocal arrangement may not exceed 14 days in the case of an informal arrangement. Effective for claims submitted on or after June 15, 2012, the reciprocal arrangement may not exceed 60 continuous days in the case of an arrangement involving per diem or other fee-for-time compensation. Providers participating in a reciprocal arrangement must be enrolled with the Alabama Medicaid Agency. The regular physical/occupational therapist should keep a record on file of each service provided by the substitute physical/occupational therapist and make this record available to Medicaid upon request. Claims will be subject to post-payment review.

37.3 Prior Authorization and Referral Requirements

Physical, Occupations, and Speech service 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.

Behavior Analysis service procedure codes require prior authorization. Refer to Chapter 4, Obtaining Prior Authorization, for general guidelines.

When filing claims for recipients enrolled in the ACHN Program, refer to Chapter 40 - ACHN to determine whether your services require a referral from the Primary Care Physician (PCP). If the EPSDT screening provider wants to render treatment services himself, the provider completes a self-referral.

After receiving a screening referral form, Medicaid providers may seek reimbursement for medically necessary services to treat or improve the defects, illnesses, or conditions identified on the referral form. The consulting provider completes the corresponding portion of this form and returns a copy to the screening provider. If services or treatment from additional providers is indicated, a copy of the referral form must be sent to those providers for their medical records. A completed Referral for Services Form must be present in the patient’s medical record that identifies the treated conditions referred as the result of an EPSDT screening or payments for these services will be recouped. The referral form must be appropriately completed by the screening physician including the screening date that the problem was identified and the reason for the referral.

Signature Requirement for Referrals: Effective May 16, 2012:
For hard copy referrals, the printed, typed, or stamped name of the primary care physician with an original signature of the physician or designee (physician or non-physician practitioner) is required. **Stamped or copied signatures will not be accepted**. For electronic referrals, provider certification is made via standardized electronic signature protocol.

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All orders must be written according to practice guidelines and state/federal law and must include the date and signature of the provider, the service(s) ordered and the recipient's name. The EPSDT referral form may be considered as the physicians' order if these guidelines are met.

37.4 Cost Sharing (Copayment)

Copayment does not apply to therapy services.

37.5 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

Therapy providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

Therapy services are billed using the CMS-1500 claim form. Medicare-related claims must be filed using the Medical Medicaid/Medicare-related Claim Form.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

37.5.1 Time Limit for Filing Claims

Medicaid requires all claims for therapy services to be filed within one year of the date of service. Refer to Chapter 5, Filing Limits, for more information regarding timely filing limits and exceptions.

37.5.2 Diagnosis Codes

The *International Classification of Diseases - 10th Revision - Clinical Modification* (ICD-10-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, P. O. Box 930876 Atlanta, GA 31193-0873 or 1-800-621-8335. American Medical Association, AMA Plaza 330 North Wabash Ave, Suite 39300 Chicago, IL 60611-5885, or 1-800-621-8335.

NOTE:

ICD-10 codes should be used for claims submitted with dates of service on/after 10/01/2015.

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NOTE:

ICD-10 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

37.5.3 Procedure Codes and Modifiers

Medicaid uses the Healthcare Common Procedure Coding System (HCPCS). HCPCS is composed of the following:

- American Medical Association's Current Procedural Terminology (CPT)
- Nationally assigned codes developed for Medicare
- Locally assigned codes issued by Medicaid. Effective for dates of service on or after 01/01/2004, use national codes.

The CPT manual lists most procedure codes required by Medicaid. This manual may be obtained by contacting the Order Department, American Medical Association, 515 North State Street, Chicago, IL 60610-9986. The (837) Professional electronic claim and the paper claim have been modified to accept up to four Procedure Code Modifiers.

Speech Therapy

Speech Therapy focuses on receptive language, or the ability to understand words spoken to you, and expressive language, or the ability to use words to express yourself. It also deals with the mechanics of producing words, such as articulation, pitch, fluency, and volume. Identifying those with communicative or oropharyngeal disorders and delays in the development of communication skills, including the diagnosis and appraisal of specific disorders and delays in those skills.

Speech Therapy is covered only when service is rendered to a recipient as a result of an identified condition(s) noted during the EPSDT Screening exam or to QMB recipient. In order for the service to be covered the diagnosis must be speech related, such as stroke (CVA) or partial laryngectomy. In order to be a covered benefit, speech therapy must be ordered by a physician and perform in an office location. Speech therapy performed in an inpatient or outpatient hospital setting, or in a nursing home 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. Speech therapy is not covered by Medicaid unless actually performed by a practitioner in person.

Use revenue codes 44x when billing speech therapy. Speech therapy providers are limited to the procedure codes listed below:

Procedure Code	***Description***	***Requires a Prior Authorization***
92521	Evaluation of speech therapy	No
92522	Evaluation of speech sound production	No
92523**	Evaluation of speech sound production with evaluation of language comprehension and expression	No
92524	Behavioral and qualitative analysis of voice and resonance	No

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Procedure Code	*Description*	*Requires a Prior Authorization*
92526	Treatment of swallowing and/ or oral feeding function	No
92507**	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual	No
92508**	Group, two or more individuals	No
92607	Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour	No
92608	Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; each additional 30 minutes	No
92610	Evaluation of swallowing function	No
96112	Administration of development test, first hour	No
96113	Administration of development test, additional 30 minutes	No
96125	Standardized cognitive performance testing (eg, Ross Information Processing Assessment) per hour, both face-to-face time administering tests to the patient and time interpreting test results and preparing the report.	No
97532	Development of cognitive skills to improve attention, memory, or problem solving, each 15 minutes	No

****Effective June 1, 2023, procedure codes 92507, 92508, and 92523 can be reimbursed for Audio-Only Telecommunication and only be used in lieu of the audio and video telecommunication where telemedicine is approved by Medicaid.**

Providers must place the "FQ" modifier on the claim to designate that the service was rendered via audio only telecommunication method.

Physical Therapy

Physical therapy services address the promotion of sensorimotor function through enhancement of musculoskeletal status, neurobehavioral organization, perceptual and motor development, cardiopulmonary status and effective environmental adaptation. This is covered based on medical necessity.

Key service functions include the following:

- Screening, evaluation and assessment to identify movement dysfunction
- Obtaining, interpreting and integrating information appropriate to program planning to prevent, alleviate or compensate for movement dysfunction and related functional problems
- Providing individual and group services or treatment to prevent, alleviate or compensate for movement dysfunction and related functional problems
- Providing developmental and functionally appropriate services

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Records are subject to retrospective review. Physical therapy records must state the treatment plan and must meet *established* medical *criteria's*. Physical therapy is subject to the following criteria:

- Physical therapy is covered in an outpatient setting 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.

If the medical criteria are not met or the treatment plan is not documented in the medical record, Medicaid may recoup payment.

Physical Therapy is not covered when provided in a physician's office. Physical therapy is covered only when prescribed by a physician. Physical therapy providers are limited to the procedure codes and max units listed below. These procedure codes cannot be span billed and must be submitted for each date of service provided. Documentation by therapist in medical record must support number of units billed on claim.

Procedure Code	***Physical Therapy***	***See Note***	***Max Units Per Day***	***Requires Prior Authorization***
95851	ROM measurements and report (separate procedure); each extremity (excluding hand) or each trunk section (spine)		10	No
95852	ROM measurements and report (separate procedure);hand, with or without comparison with normal side		1	No
96112	Administration of development tests, first hour		1	No
96113	Administration development test, additional 30 minutes		1	No
97161	Evaluation of physical therapy, low complexity, typically 20 minutes		1	No
97162	Evaluation of physical therapy, moderate complexity, typically 30 minutes		1	No
97163	Evaluation of physical therapy, high complexity, typically 45 minutes		1	No
97164	Re-evaluation of physical therapy, typically 20 minutes		1	No
97010	Application of a modality to one or more areas; hot or cold packs	3, 5	1	No

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Procedure Code	*Physical Therapy*	*See Note*	*Max Units Per Day*	*Requires Prior Authorization*
97012	Traction, mechanical	5	1	No
97014	Electrical stimulation, unattended	2	4	No
97016	Vasopneumatic device	5	1	No
97018	Paraffin bath	3, 5	1	No
97022	Whirlpool	3	1	No
97024	Diathermy	5	1	No
97026	Infrared	5	1	No
97028	Ultraviolet		1	No
97032	Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes	3	4	No
97034	Contrast baths, each 15 minutes	3	4	No
97035	Ultrasound, each 15 minutes	3	4	No
97036	Hubbard tank, each 15 minutes	3	4	No
97110	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, ROM and flexibility	3, 5	4	No
97112	Neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and proprioception	3, 5	1	No
97113	Aquatic therapy with therapeutic exercises	5	1	No
97116	Gait training (includes stair climbing)	5	1	No
97124	Massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion).	3, 5	1	No
97140	Manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes	5	1	No
97150	Therapeutic procedure(s), group (2 or more individuals)	5	1	No
97530	Therapeutic activities, direct (one on one) patient contact by the provider, (use of dynamic activities to improve functional performance), each 15 minutes	3, 5	4	No
97533	Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one on one) patient contact by the provider, each 15 minutes		4	No
97535	Self-care/home management training (e.g., activities of daily living (ADL)	3, 5	4	Yes

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Procedure Code	*Physical Therapy*	*See Note*	*Max Units Per Day*	*Requires Prior Authorization*
	and compensatory training, meal preparation, safety procedures, and instructions in use of adaptive equipment), direct one on one contact by provider each 15 minutes.			
97542	Wheelchair management/propulsion training, each 15 minutes	3, 5	4	No
97597	Removal of devitalized tissue From wounds		1	No
97598	Removal of devitalized tissue From wounds		8	No
97750	Physical performance test or measurement, (e.g., musculoskeletal, functional capacity) with written report, each 15 minutes	3	12	No
97760	Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(s), lower extremity(s) and/or trunk, each 15 minutes	3, 4, 5	4	No
97761	Prosthetic training, upper and/or lower extremity(s), each 15 minutes	3	4	No
97762	Checkout for orthotic/prosthetic, use, established patient, each 15 minutes	3	4	No

NOTE:

1. Reserved

2. 97014 cannot be billed on same date of service as procedure code 20974, 20975 or 20982.

3. When a physical therapist and an occupational therapist perform the same procedure for the same recipient for the same day of service, the maximum units reimbursed by Medicaid will be the daily limit allowed for procedure, not the maximum units allowed for both providers.

4. 97760 should not be reported with 97116 for the same extremity.

5. Procedures 97010, 97012, 97016, 97018, 97024, 97026 (therapy procedures) must be billed with one of the following codes: 97014, 97020, 97110, 97112, 97113, 97116, 97124, 97140, 97150, 97530, 97535, or 97542 (therapeutic treatment).

Occupational Therapy

Occupational Therapy is a service that addresses the functional needs related to adaptive development, adaptive behavior and sensory, motor and postural development. These services are designed to improve the functional ability to perform tasks in the home and community settings.

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Occupational therapy procedure codes cannot be span billed and must be submitted for each date of service provided. Some codes may require attainment of prior authorization before services are rendered. Documentation by therapist in medical record must support number of units billed on claim. Use revenue code 43x when billing claims for occupational therapy.

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 providers are limited to the following procedure codes:

Code	***Description***	***See Note***	***Max Units Per Day***	***Requires Prior Authorization***
96112	Administration of development tests, first hour		1	No
96113	Administration of development tests, additional 30 minutes		1	No
96125	Standardized cognitive performance testing (eg, Ross Information Processing Assessment) per hour, both face-to-face time administering tests to the patient and time interpreting test results and preparing the report.		1	No
97165	Evaluation of occupational therapy, low complexity, typically 30 minutes		1	No
97166	Evaluation of occupational therapy, moderate complexity, typically 45 minutes		1	No
97167	Evaluation of occupational therapy established plan of care, high complexity, typically 60 minutes		1	No
97168	Re-evaluation of occupational therapy established plan of care, typically 30 minutes		1	No
97010	Application of a modality to one or more areas; hot or cold packs	1, 3, 5	1	No
97018	Paraffin bath	1, 3, 5	1	No
97022	Whirlpool	3	1	No
97032	Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes	3	4	No
97034	Contrast baths, each 15 minutes	3	4	No
97035	Ultrasound, each 15 minutes	3	4	No
97036	Hubbard tank, each 15 minutes	3	4	No
97110	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility	3, 5	4	No
97112	Neuromuscular reeducation of	3, 5	1	No

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Code	*Description*	*See Note*	*Max Units Per Day*	*Requires Prior Authorization*
	movement, balance, coordination, kinesthetic sense posture, and proprioception			
97124	Massage, including effleurage, petrissage, and/or tapotement (stroking, compression, percussion)	3, 5	1	No
97530	Therapeutic activities, direct (one on one) patient contact by the provider, (use of dynamic activities to improve functional performance), each 15 minutes	3, 5	4	No
97532	Development of cognitive skills to improve attention, memory, or problem solving, each 15 minutes			No
97533	Sensory technique to enhance processing and adaptation to environmental demands, each 15 minutes		4	No
97535	Self-care / home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of adaptive equipment) direct one on one contact by provider, each 15 minutes.	3, 5	4	Yes
97542	Wheelchair management /propulsion training, each 15 minutes	3, 5	4	No
97597	Removal of devitalized tissue from wounds		1	No
97598	Removal of devitalized tissue from wounds		8	No
97750	Physical performance test or measurement (e.g., musculoskeletal, functional capacity) with written report, each 15 minutes	3	12	No
97760	Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(s), lower extremity(s) and/or trunk, each 15 minutes	3	4	No
97761	Prosthetic training, upper and/or lower extremity(s), each 15 minutes	3	4	No
97762	Checkout for orthotic/prosthetic, use, established patient, each 15 minutes	3	4	No

NOTE:

Procedure code 96125 used for standardized cognitive performance testing should not be billed with autism diagnostic testing codes 96112 and 96113.

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Applied Behavior Analysis (ABA) Therapy

ABA therapy is the behavioral treatment approach most commonly used with children with Autism Spectrum Disorder (AS).

Techniques based on ABA include:

- Discrete Trial Training, Incidental Teaching, Pivotal Response Training, and Verbal Behavioral Intervention
- Structured environment, predictable routines, individualized treatment, transition and aftercare planning, and significant family involvement
- Attempts to increase skills related to behavioral deficits and reduce behavioral excesses including eliminating barriers to learning
- Behavior deficits may occur in the areas of communication, social and adaptive skills, but are possible in other areas as well.
    - Examples of deficits may include: a lack of expressive language, inability to request items or actions, limited eye contact with others, and inability to engage in age-appropriate self-help skills such as tooth brushing or dressing.
    - Examples of behavioral excesses may include, but are not limited to: physical aggression, property destruction, elopement, self-stimulatory behavior, self-injurious behavior, and vocal stereotypy.

Applied behavior analysis therapy is a service that may be used for children diagnosed with F84.0 Autistic Disorder, F84.3 Other Childhood Disintegrative Disorders, F84.5 Asperger's, F84.8 Other Pervasive Developmental Disorders, F84.9 Pervasive Developmental Disorder Unspecified.

Applied behavior therapy procedure codes cannot be span billed and must be submitted for each date of service provided. Most codes require attainment of prior authorization before services are rendered. Documentation by the therapist in the medical record must support the number of units billed on claim. An ABA Therapy Behavior Assessment Form is required as part of the support documentation for the prior authorization request. This form can be accessed by visiting the following link on the Medicaid website: http://www.medicaid.alabama.gov/content/4.0_Programs/4.2_Medical_Services/4.2.3_EPSDT.aspx .

Individual behavior therapy providers are limited to the following procedure codes:

Code	Description	Requires Prior Authorization
97151	Behavior Identification Assessment	No
97152	Observational F/U assessment	Yes
0362T	Exposure Behavioral F/U assessment	Yes
97153	Adaptive Behavior Tx	Yes
97154	Group Adaptive Behavior Tx	Yes
97158	Social Skills Group	Yes
0373T	Exposure Adaptive Behavior Tx	Yes
97155	Adaptive Behav Modification	Yes
97156	Family Adaptive Behavior Tx Guidance	Yes
97157	Multiple Family, Group Tx Guidance	Yes

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Positive Behavior Support (PBS) Services are a set of researched-based strategies that combine behavioral and biomedical science with person-centered, valued outcomes and systems change to increase quality of life and decrease problem behaviors by teaching new skills and making changes in a waiver recipient's environment.

PBS services may be used for children diagnosed with F-70 to F-79 Intellectual Disabilities and should billed with 0373T - Exposure Adaptive Behavior Tx with prior authorization as described above.

For ABA therapy or PBS services listed above provided via telemedicine, enrolled providers are eligible to participate in the Telemedicine Program to provide medically necessary telemedicine services to Alabama Medicaid eligible recipients. In order to participate in the telemedicine program:

- Providers must be enrolled with Alabama Medicaid with a specialty type of 931 (Telemedicine Service).
  - To be enrolled with the 931 specialty, providers must submit the Telemedicine Service Agreement/Certification form which is located on the Medicaid website at: www.medicaid.alabama.gov. Electronic signatures will be acceptable for the telemedicine agreement. The agreement may be uploaded through the provider web portal along with a request to add the 931 specialty. See Chapter 2 – Becoming a Medicaid Provider for further information.
  - Providers must obtain prior consent from the recipient before services are rendered. A sample recipient consent form is attached to the Telemedicine Service Agreement.

Services must be administered via an interactive audio and video telecommunications system which permits two-way communication between the distant site provider and the origination site where the recipient is located (this does not include a telephone conversation, electronic mail message, or facsimile transmission between the provider, recipient, or a consultation between two providers).

Telemedicine health care providers shall ensure that the telecommunication technology and equipment used at the recipient site and at the provider site, is sufficient to allow the provider to appropriately evaluate, diagnose, and/or treat the recipient for services billed to Medicaid. Transmissions must utilize an acceptable method of encryption adequate to protect the confidentiality and integrity of the transmission information. Transmissions must employ acceptable authentication and identification procedures by both the sender and the receiver.

The provider shall maintain appropriately trained staff, or employees, familiar with the recipient's treatment plan, immediately available in-person to the recipient receiving a telemedicine service to attend to any urgencies or emergencies that may occur during the session. The provider shall implement confidentiality protocols that include, but are not limited to:

- specifying the individuals who have access to electronic records; and
- usage of unique passwords or identifiers for each employee or other person with access to the client records; and
- ensuring a system to prevent unauthorized access, particularly via the Internet; and

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- ensuring a system to routinely track and permanently record access to such electronic medical information

These protocols and guidelines must be available to inspection at the telemedicine site and to the Medicaid Agency upon request.

Claims submitted for ABA therapy or PBS services delivered via telemedicine should include a valid place of service listed in 37.5.4 with the modifier GT.

NOTE:

Refer to Chapter 108, Early Intervention Services for therapy delivered to infants/children enrolled in Alabama's Early Intervention System (AEIS).

37.5.4 Place of Service Codes

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

POS Code	*Description*
11	Office
12	Home (for ABA therapy only)

37.5.5 Required Attachments

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

- Claims With Third Party Denials

NOTE:

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

Refer to Chapter 5, Required Attachments, for more information on attachments.

37.6 For More Information

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

Resource	Where to Find It
CMS-1500 Claim Filing Instructions	Chapter 5
Medical Medicaid/Medicare-related Claim Filing Instructions	Chapter 5
Medical Necessity/Medically Necessary Care	Chapter 7
EPSDT	Appendix A
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N

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38 Anesthesiology

Administration of anesthesia is a covered service when administered by or directed by a duly licensed physician for a medical procedure that is covered by Medicaid.

The policy provisions for anesthesia can be found in the Alabama Medicaid Agency Administrative Code, Chapter 6.

38.1 Enrollment

Gainwell 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.

Gainwell also enrolls Certified Registered Nurse Anesthetists (CRNA), and Anesthesiology Assistants (AA) who are employed by a Medicaid enrolled physician or hospital.

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

National Provider Identifier, Type, and Specialty

A provider who contracts with Alabama Medicaid as an anesthesiologist, CRNA, or AA provider is added to the Medicaid systems with the NPIs provided at the time application is made. Appropriate specialty codes are assigned to enable the provider to submit requests and receive reimbursements for anesthesia-related claims.

NOTE:
The 10-digit NPI is required when filing a claim.

Anesthesiologists are assigned a provider type of 31 (Physician). CRNAs are assigned a provider type of 09. AAs are assigned a provider type of 10 Valid specialties for the above include the following

- Anesthesiology Assistant (101)
- CRNA (094)

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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 and CRNAs must be submitted and approved before the enrollment process can be initiated:

- Copy of current state license
- Copy of current certifications (CRNA or AA)

38.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations. Refer to Chapter 7, Understanding Your Rights and Responsibilities as a Provider, for general criteria on Medical Necessity/ Medically Necessary Care.

Administration of anesthesia is a covered service when administered by or directed by a duly licensed physician for a medical procedure that is covered by Medicaid. Medical direction by an anesthesiologist of more than four Certified Registered Nurse Anesthetists (CRNAs) or Anesthesiology Assistants (AAs) concurrently will not be covered.

Administration of anesthesia by an AA is a covered service when the AA has met the qualifications and standards set forth in the Alabama Board of Medical Examiners. The AA must enroll and receive a NPI to bill the Alabama Medicaid Program. Reimbursement shall be made only when the AA performs the administration of anesthesia under the direct medical supervision of the anesthesiologist

Administration of anesthesia by a self-employed CRNA is a covered service when the CRNA has met the qualifications and standards set forth in Rule No. 610-X-9-.01 through 610-X-9-.04 of the Alabama Board of Nursing Administrative Code. The CRNA must enroll with a valid NPI to bill under the Alabama Medicaid Program. When billing for anesthesia services, providers shall follow the guidelines set forth in the current Relative Value Guide published by the American Society of Anesthesiologists for basic value and time units.

For billing purposes, anesthesia services rendered with medical direction for one CRNA or AA is considered a service performed by the anesthesiologist. The definition of medical direction is an anesthesiologist medically directing four concurrent cases (CRNA/AA) or less. In order to bill for medical direction, the anesthesiologist must be immediately physically available at all times. Addressing an emergency of short duration, or rendering the requisite CRNA or AA direction activities (listed below in a. through g.), within the immediate operating suite is acceptable as long as it does not substantially diminish the scope of the supervising anesthesiologist's control. If a situation occurs which necessitates the anesthesiologist’s personal continuing involvement in a particular case, medical direction ceases to be available in all other cases.

In order for the anesthesiologist to be reimbursed for medical direction activities of the CRNA or AA, the anesthesiologist must document the performance of the following activities:

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- Performs a pre-anesthesia examination and evaluation
- Prescribes the anesthesia plan
- Personally participates in the most demanding procedures in the anesthesia plan, including induction as needed, and emergencies
- Ensures that any procedures in the anesthesia plan that he or she does not perform are performed by a qualified individual
- Monitors the course of anesthesia administration at frequent intervals
- Remains immediately physically available for immediate diagnosis and treatment of emergencies
- Provides indicated post-anesthesia care

A necessary task or medical procedure may be executed while concurrently medically directing CRNAs or AAs only if the task or procedure is one which may be: (1) immediately interruptible without compromising the wellbeing, quality of care, or health of the recipient and (2) is executed in an area close enough to the operating rooms where the CRNAs and AAs are being medically directed and that will permit the physician to remain in compliance with the requirements of being immediately physically available. Examples of an “area close enough to the operating rooms” are the Post-Anesthesia Care Unit (PACU) or receiving room. A task or procedure that may be stopped instantly is defined as one of limited difficulty and brief duration so that if it is stopped instantly, it would not interfere with the quality of care, wellbeing, or health of the recipient. There are two exceptions to the above:

1. Acting in response to urgencies of short duration or medical emergencies (e.g., ACLS provision, intubation, starting difficult intravenous (IV) lines that without them would reduce the recipient’s quality of care, etc.)
2. Labor epidural placement and management

The execution of a trigger point injection or an epidural steroid injection while medically directing is permissible when requested by another physician. The 1:4 ratio should be maintained while the trigger point injection or the epidural steroid injection is being executed. The consult for the execution of the aforementioned may serve as the second, third, or fourth simultaneous case. Therefore the execution of these limited pain services is disallowed while medically directing four simultaneous anesthetics. The ability to respond to urgent or emergent needs in the hospital (operating room, labor and delivery room, or anywhere in the hospital where his/her responsibility lies) may not be decreased at any time and is the responsibility of the anesthesiologist who is medically directing. The intent of this exception is to allow for provision of commonly requested procedures and to improve effectiveness. However, this exception does not include consults to diagnose. Diagnosis of chronic pain and treatment of complex problems is not allowed while simultaneously medically directing CRNAs and AAs.

Global Anesthesia Definition

The Agency has identified certain procedures to be included in the global payment for the anesthesia services. These procedures include but are not limited to the following: general anesthesia, regional anesthesia, local anesthesia, supplementation of local anesthesia, and other supportive

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treatment administered to maintain optimal anesthesia care deemed necessary by the anesthesiologist during the procedure.

Anesthesia services include:

- All customary preoperative and postoperative visits,
- Local anesthesia during surgery,
- The anesthesia care during the procedure,
- The administration of any fluids deemed necessary by the attending physician, and any usual monitory procedures

Interpretation of non-invasive monitoring to include EKG, temperature, blood pressure, pulse, breathing, electroencephalogram and other neurological monitoring,

Monitoring of left ventricular or valve function via transesophageal echocardiogram,

Maintenance of open airway and ventilatory measurements and monitoring,

Oximetry, capnography and mass spectrometry.

Monitoring all fluids used during cold cardioplegia through non-invasive means. Additional claims for such services should not be submitted.

Placement of lines such as arterial catheterizations and insertion and placement of pulmonary artery catheters (e.g., Swan-Ganz) for monitoring will no longer be included in the global anesthesia reimbursement when billed with other procedures but will be allowed to be billed using the same guidelines outlined in this chapter under “Special Situations for Anesthesia”. The time of placement of invasive monitors and who placed them should be documented in the medical record. Verification of anesthesia time units may be subject to post-payment audits. Billing for anesthesia time while placing invasive monitors is not allowed unless the patient required general anesthesia for placement.

The time anesthesia starts is at the beginning of induction via the injection or inhalation of an anesthetic drug or gas and ends at the time the recipient is transferred to the recovery room or post anesthesia care unit (PACU). Induction is defined as the time interval between the initial injection or inhalation of an anesthetic drug or gas until the optimum level of anesthesia is reached. The recipient must be prepared by the anesthesiologist prior to induction and must be assessed by the anesthesiologist immediately after the surgical procedure. Up to 15 minutes are allowed for the preparation of anesthesia, and up to 15 minutes are allowed after the operation (for transfer of the recipient to the receiving room, recovery room, or PACU). It is inappropriate to bill for anesthesia time while the patient is receiving blood products or antibiotics in the holding area or waiting in a holding area, or waiting in the operating room more than 15 minutes prior to induction.

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Local anesthesia is usually administered by the attending surgeon and is considered to be part of the surgical procedure being performed. Additional claims for local anesthesia by the surgeon should not be filed. Any local anesthesia administered by an attending obstetrician during delivery (i.e., pudendal block or paracervical block) is considered part of the obstetrical coverage. Additional claims for local anesthesia administered by an attending obstetrician during delivery should not be filed.

When regional anesthesia (i.e., nerve block) is administered by the attending physician during a procedure, the physician's fee for administration of the anesthesia is billed at one-half the established rate for a comparable service when performed by an anesthesiologist. When regional anesthesia is administered by the attending obstetrician during delivery (i.e., saddle block or continuous caudal), the obstetrician's fee for administration of the anesthesia will be billed at one-half the established rate for a comparable service performed by an anesthesiologist. When regional anesthesia is administered by an anesthesiologist during delivery or other procedure, the anesthesiologist's fee will be covered and should be billed separately.

When an epidural is performed as part of maternity labor/delivery by a resident, modifiers **AA** and **GC** must be billed along with the procedure code to identify the service is administered under the direction of a physician **(AA**), and performed by the resident **(GC).** When the epidural is performed by a physician in the absence of a resident, use modifier **AA** only.

When a medical procedure is a non-covered service under the Alabama Medicaid Program, the anesthesia for that procedure is also considered to be a non-covered service.

A primary anesthesia procedure is included in the procedure code range of 00100-01997 as noted in the Relative Value Guide.

NOTE:

Medical record documentation should clearly support and reflect physician services. Post-payment reviews may be performed.

Special Situations for Anesthesia

If two procedures of equal unit value are billed, the first procedure will be paid and the second one will deny because the subsequent procedure is included in the primary anesthesia charge.

If two procedures are billed with different unit values, the procedure with the greatest unit value will pay and the other procedure will deny because the subsequent procedure is included in primary anesthesia charge.

The anesthetic agent for nerve blocks (CPT codes 64400-64530) is included in the reimbursement fee for the performance or administration of the nerve block. No additional procedures should be filed for the nerve block medication.

Anesthesia for CT Scans or MRI/MRA Procedures is not covered for anesthesiologists. The attending/admitting physician is responsible for ordering the necessary measure(s) to ensure the patient is prepared for these tests.

Monitored Anesthesia Care is a covered service.

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Medicaid does not cover physical status modifiers.

Standby anesthesia is not payable under Medicaid.

Consultations

A consultation for anesthesia performed on the day of or days before a procedure is considered part of the global procedure and is not a separately reimbursable item.

There are two exceptions to the above as outlined below.

- A recipient with chronic intractable pain receives a consult from an anesthesiologist for the chronic intractable pain, or
- A recipient receives a consult from an anesthesiologist to have an anesthesia procedure performed but ends up not receiving the anesthesia, e.g., the surgery is canceled due to complications.

Post-Operative Pain Management and Epidural Catheters

Surgeons routinely provide necessary post-operative pain management services and are reimbursed for these services through the global surgery fee. The surgeon should manage post-operative pain except under extraordinary circumstances. Procedures involving major intra-abdominal, vascular, orthopedic, and intrathoracic procedures will be covered for post-operative pain management by an anesthesiologist when medically indicated. Postoperative pain management services is not covered by non-physicians.

Under certain circumstances an anesthesia practitioner may separately report an epidural or peripheral nerve block injection or catheter for post-operative pain management when the surgeon requests assistance with post-operative pain management. Refer to the NCCI manual at https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index for specific coding details and further information.

Claims for post-operative pain management that have denied require manual review. A paper claim, which must include Form 402, a clean Red Drop Ink CMS Form 1500, and supporting medical documentation, must be submitted to the Alabama Medicaid Agency in order to be processed. Please send manual review requests to:

Alabama Medicaid Agency
Attn: Dental / EPSDT / Physician Division
501 Dexter Avenue
P.O. Box 5624
Montgomery, AL 36103-5624

The definition for post-operative pain management is the management of a recipient's pain beyond, or separate from, the recovery room or operating room. The separately identifiable physician-recipient encounter and management should occur outside the intraoperative area. A separately identifiable physician-recipient encounter reflecting the prescription of medication, associated monitoring, adjustment(s) of medication, and ongoing assessments for complications should be clearly reflected in the medical record documentation.

No additional payment is allowed for an injection of Duramorph or other analgesic agents as a boost at the end of an anesthesia procedure (using the

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same catheter used for the epidural or spinal anesthesia) without a separately identifiable physician-recipient encounter including the prescription of medication, associated monitoring, adjustment(s) of medication, and ongoing assessments for complications. However, if there is a separately identifiable physician-recipient encounter on subsequent post-op days, where the physician provides post-operative analgesic orders and manages post-operative analgesic complications, daily management of epidural or subarachnoid drug administration may be billed.

If a recipient receives general anesthesia and consequently requires additional pain control such as an epidural injection or an epidural catheter placement on the same day as the general anesthesia, the single injection or catheter placement will be reimbursed at one-half of the allowable. However, catheter placement and daily management of an epidural catheter is not allowed on the same date of service. When the physician provides a separately identifiable physician-recipient encounter to manage and evaluate the catheter and it is reflected in the medical record, this coverage is satisfactory for a reasonable period of time over the consecutive post-operative days.

Patient Controlled Analgesia

Patient controlled analgesia (PCA) services are reimbursable when they are administered by an anesthesiologist and are performed for the control of post-operative pain. A separately identifiable physician-recipient encounter should be reflected in the medical record documentation. PCA pumps are usually administered through an intravenous (IV) line or the PCA pump is connected to an epidural catheter line.

When an anesthesiologist provides the management of the PCA pump through an IV line, the anesthesiologist will be allowed a total of four units and will be considered a global payment for the management regardless of the number of days the recipient remains on the pump. Use procedure code 96522 for daily hospital management of intravenous patient-controlled analgesia.

The anesthesiologist should use the appropriate procedure code(s) when filing claims for a single injection or for an injection including catheter placement (epidural, subarachnoid, cervical, thoracic, lumbar, or sacral) when the PCA pump is connected to an epidural line. Placement of the epidural catheter and daily management of a subarachnoid or epidural catheter is not reimbursable on the same date of service. Daily management of a subarachnoid or epidural catheter is reimbursable on subsequent days. Delivery of pain medication through intermittent injections, a regular infusion, or by a PCA pump is included in the management of an epidural line whether a registered nurse or a physician administers it. Additional units for a PCA pump that is connected to an epidural line is not separately reimbursable.

The global surgical reimbursement fee to the surgeon includes the management of a PCA pump for post-operative pain control and is not a separately reimbursable item. Similarly, a physician’s global medical service reimbursement includes the management of a PCA pump for recipients with chronic pain control or terminal cancer and is not separately reimbursable.

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Intractable Pain and Epidural Catheters

Some forms of conventional therapy such as oral medication, physical therapy, or a TENS unit may not relieve recipients with intractable pain. Placement of an epidural catheter may be allowed when medically necessary for recipients with intractable pain. Reimbursement for daily management is allowed when it is medically necessary and is a separately identifiable physician-recipient encounter is clearly documented in the medical record by the anesthesiologist. Placement of an epidural catheter and daily management of an epidural catheter is not reimbursable on the same date of service.

38.3 Prior Authorization and Referral Requirements

Anesthesiology procedure codes generally do not require prior authorization. Refer to Chapter 4, Obtaining Prior Authorization, for general guidelines.

When filing claims for recipients enrolled in the Alabama Coordinated Health Network (ACHN) Program, refer to Chapter 40, ACHN to determine whether your services require a referral from the Primary Care Provider (PCP).

38.4 Cost Sharing (Copayment)

Copayment amount does not apply to services provided by Anesthesiologists, Certified Registered Nurse Anesthetists or Anesthesiology Assistants.

38.5 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

Providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When filing a claim on paper, a CMS-1500 claim form is required. Medicare-related claims must be filed using the Medical Medicaid/Medicare-related Claim Form.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

38.5.1 Time Limit for Filing Claims

Medicaid requires all claims for Anesthesiologists, CRNAs and AAs to be filed within one year of the date of service. Refer to Section 5.1.4, Filing Limits, for more information regarding timely filing limits and exceptions.

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38.5.2 Diagnosis Codes

The International Classification of Diseases -10th Revision - Clinical Modification (ICD-10-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, AMA Plaza 330 North Wabash Ave, Suite 39300 Chicago, IL 60611-5885, or 1-800-621-8335.

NOTE:

ICD-9 codes should be used for claims submitted with dates of service prior to or equal to 09/30/2015.

ICD-10 codes should be used for claims submitted with dates of service on/after 10/01/2015.

NOTE:

ICD-9 or ICD-10 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

38.5.3 Procedure Codes and Modifiers

Anesthesia providers are required to utilize the appropriate anesthesia code identified in the current Relative Value Guide published by the American Society of Anesthesiologists. Time in attendance should be billed by listing **total minutes** of anesthesia time in block 24G of the CMS-1500 claim form. Type of service "7" should be used for billing anesthesia codes (00100-01997). The (837) Institutional electronic claim and the paper claim have been modified to accept up to four Procedure Code Modifiers. Effective October 1, 2004 to bill for code 90784, bill the first line item with the code and one unit. Bill the second line item with code 90784 with modifier 76 (repeat procedure) and 3 units.

Gainwell will calculate total units by dividing the total minutes (reported in block 24G) by 15, rounding up to the next whole number, and adding the time units to the auto-loaded base unit values. The base unit values are derived from the ASARVG for CPT-4 anesthesia codes.

Qualifying Factors

Historically, beginning on June 14, 2002, qualifying factors were reimbursable.

However, effective July 31, 2013 qualifying factors are no longer reimbursable.

Medical Direction - 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

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Medical direction should only be billed when supervision of the CRNA or AA is rendered by an anesthesiologist. If a procedure is medically supervised by the surgeon, the claim should be billed as if the service were not medically directed.

Medical Direction - Anesthesiologists

Medically directed services are defined as anesthesia services that are medically directed by an anesthesiologist for 1, 2, 3, or 4 qualified individuals, i.e., CRNAs, AAs, interns, residents or combinations of these individuals.

When billing for medically directed services, anesthesiologists should utilize the modifiers listed below:

- QY for medically directed services of 1 qualified individual, i.e., CRNA, AA, intern, resident or combinations of these individuals (effective for 01/01/99)
- QK for medically directed services of 2, 3, or 4 qualified individuals, i.e., CRNAs, AAs, interns, residents or combinations of these individuals.

The payment amount for the physician's service and the qualified individual, i.e., CRNA, AA, intern, resident or combinations of these individuals is 50% of the allowance otherwise recognized had the service been furnished by the anesthesiologist alone.

Medical Direction – Resident

Residents may bill anesthesia services under the supervision of the teaching physician. They are allowed to bill anesthesia procedure codes using the teaching physician's provider number along with an AA and GC modifier.

The term resident includes interns and fellows.

Please refer to the medical supervision requirements indicated in the previous section for billing requirements when concurrent cases (limited to 4) are being supervised by the same physician.

Other Anesthesia Modifiers

Other appropriate anesthesia modifiers for anesthesiologists include the following:

Modifier	***Description***
AA	Anesthesia services performed personally by an Anesthesiologist

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, and AA. Medical directing five or more concurrent cases is not allowed.

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38.5.4 Referring Provider Information

Effective February 23, 2008, anesthesia providers must submit the NPI number of the referring surgeon/physician on the claim. If you file hard copy, the NPI number should be populated in block 17a of the CMS 1500 claim form. For those who file electronically, you should submit the referring surgeon/physician's NPI number in REF02 of the 837P. This is necessary for proper claims processing.

Anesthesiologists should use "OTH000" as the referring or attending NPI number for providers who are not assigned a NPI number by Medicare. For example, when providing anesthesia services for recipients who are being treated by dental providers, please use "OTH000" as the NPI number in block 17a of the CMS 1500 form. Use "OTH000" in REF02 and the ID qualifier 1G in REF 01 when filing claims electronically on the 837P. If you use PES software or a vendor, please make sure your software has been updated to accommodate this change. As a reminder, claims for anesthesia providers not containing this information will deny.

38.5.5 Place of Service Codes

Please refer to Chapter 21 for applicable place of service codes for CRNA providers.

38.5.6 Required Attachments

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

- Claims With Third Party Denials

NOTE:

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

Refer to Section 5.8, Required Attachments, for more information on attachments.

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38.6 For More Information

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

Resource	Where to Find it
CMS-1500 Claim Filing Instructions	Chapter 5
Medical Medicaid/Medicare-related Claim Filing Instructions	Chapter 5
Medical Necessity/Medically Necessary Care	Chapter 7
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 Psychiatric Inpatient Hospitalization Treatment Facilities (Recipients ages 21-64)

For purpose of this chapter, an inpatient is a person, age 21 through 64 years of age, who has been admitted to an Institutions for Mental Diseases (IMDs) specializing in the diagnosis, treatment, and care of serious mentally ill recipients, for the purpose of maintaining or restoring them to the greatest possible degree of health and independent functioning.

The policy provisions for IMDs can be found in the Alabama Medicaid Agency Administrative Code, Chapter 5.

39.1 Enrollment

Gainwell enrolls IMD 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 and are approved facilities under the Section 1115 Institutions for Mental Disease Waiver for Serious Mental Illness (Number 11-W-00371/4).

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

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

National Provider Identifier, Type, and Specialty

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

NOTE:
The 10-digit NPI is required when filing a claim.

IMDs are assigned a provider type of 01 (Hospital). The valid specialty for IMDs is (008).

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Enrollment Policy for Institutions for Mental Diseases Providers

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

- Receive certification for participation in the Medicaid/Medicare program
- Be accredited by the Joint Commission on Accreditation of Healthcare Organizations
- Specialize in the care and treatment of patients with serious mental illness
- Have on staff at least one full-time board-certified psychiatrist; or a full-time board certified adult psychiatrist with a minimum of 3 years' experience caring for patients 21 through 64 years of age
- Employ only staff who meet training certification standards in the area of adult psychiatry as defined by the State's mental health authority
- 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

  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.

Change of Ownership (CHOW) and Closures

Medicaid will mirror Medicare's Change of Ownership (CHOW) policy. Refer to Chapter 19, Hospital for additional information on Change of Ownership.

39.2 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 Chapter 7, Understanding Your Rights and Responsibilities as a Provider, for general criteria on Medical Necessity/ Medically Necessary Care.

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 ages 21 to 64, are covered services when provided under the following circumstances:

- Psychiatric services are provided in an IMD exclusively for the treatment of persons ages 21 to 64 with serious mental illness
- Psychiatric services are provided under the direction of a licensed psychiatrist
- The IMD providing services is enrolled as a Medicaid provider

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- The recipient is admitted to the psychiatric facility during the entire hospitalization

IMD services for recipients ages 21 to 64 years are unlimited if deemed medically necessary and the admission and/or the continued stay reviews meet the approved psychiatric criteria.

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 Form #372, which is the Certification of Need for Services. This form must be kept in the patient's record.

The Certificate of Needs 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 Certificate of Needs 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.

The independent team shall complete and sign a Certification of Need for Services: Form (#372). This form may be obtained from the Mental Health Program Manager at the Alabama Medicaid Agency.

Medical, Psychiatric, and Social Evaluation

Before admission to an IMD 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 IMD or continued care in the psychiatric facility, for individuals who apply for Medicaid while in the facility

Plan of Care/Treatment Plan

The attending physician or staff physician must establish a written treatment plan of care for each individual before admission to a mental hospital and before authorization of payment.

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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 as needed or every 30 days.

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 treatment 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 IMD must do the following:

- Have in effect a written UR Plan that provides for review of each recipient's need for services that the facility furnishes to the recipient
- Maintain recipient information required for UR, which includes the certification of need for service and the plan of care
- Provide a copy of the UR Plan and any subsequent revisions to Medicaid for review and approval

Provider Preventable Conditions (PPCs)

Provider Preventable Conditions (PPCs) are clearly defined into two separate categories: Healthcare Acquired Conditions and Other Provider Preventable Conditions (OPPCs).

Healthcare Acquired Conditions include Hospital Acquired Conditions (HACs).

OPPCs include but are not limited to the following: medication given to the wrong patient, wrong medication, wrong dose, wrong route, wrong time, wrong documentation in the medication administration records (MARs), wrong reason, and wrong response.

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

To be reportable, PPCs must meet the following criteria:

- The PPC must be reasonably preventable as determined by a root cause analysis or some other means.
- The PPC must be within the control of the provider.
- The PPC must be clearly and unambiguously the result of a preventable mistake made and hospital procedures not followed, and not an event that could otherwise occur.

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- The PPC must result in significant harm. The OPPCs for consideration should be limited to those that yield a serious adverse result. Serious adverse result is defined as one that results in death, a serious disability or a substantial increase in the duration and/or complexity of care that is well beyond the norm for treatment of the presenting condition. A serious disability is defined as a major loss of function that endures for more than 30 days, is not present at the time services were sought and is not related to the presenting condition.
- Any process for identifying non-payable events must actively incorporate some element of case-by-case review and determination. While the source and cause of some OPPCs may be clear, most would require further investigation and an internal root cause analysis to determine the cause of the serious preventable event and to assign ultimate accountability.

Pursuant to these guidelines, hospitals will not seek payments for additional days directly resulting from a PPC.

Reporting Other Provider-Preventable Conditions (OPPCs)

The following OPPCs related to the administering of medication(s) and documentation provided in the medication administration records (MARs) must be reported to Medicaid by encrypted emailing of the required information to:

adverseevents@medicaid.alabama.gov Reportable “OPPCs” include but are not limited to:

- Wrong patient
- Wrong medication
- Wrong dose
- Wrong route
- Wrong time
- Wrong documentation
- Wrong reason
- Wrong response

Reports will require the following information: Recipient first and last name, date of birth, Medicaid number, date event occurred and event type.

The IMDs may use documentation from the physician’s qualifying diagnoses to identify Present of Admission which must be documented within 72 hours of the occurrence. Medicaid also recommends that the event be reported to Medicaid via e-mail within 45 days of occurrence.

Non-payment of provider preventable conditions shall not prevent access to services for Medicaid beneficiaries.

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

Reductions in Provider payment may be limited to the extent that the following apply:

- The Identified PPC would otherwise result in an increase in payment.
- IMDs are paid based on a daily per diem rate. It is the responsibility of the hospital to identify any Health Care-Acquired Condition and not seek payment for any additional days that have lengthened a recipient’s stay due to a PPC.

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In reducing the amount of days: Hospitals are to report a value code of '81' on the UB-04 claim form along with any non-covered days and the amount field must be greater than '0'.

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

- Y-Yes. Diagnosis was present at time of inpatient admission
- N-No. Diagnosis was not present at time of inpatient admission
- U-No information in the record. Documentation insufficient to determine if the condition was present at the time of inpatient admission
- W-Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission

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

Payment

Payment for inpatient services provided by IMDs for individuals ages 21 to 64 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.

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.

39.3 Inpatient Utilization Review

1. The determination of the level of care will be made by a licensed nurse of the hospital staff
2. All admissions will be retrospectively reviewed by the Medicaid Agency or designee as needed
3. For an individual who applies for Medicaid while in the facility, a Psychiatric Admission form must be signed by the attending physician at the time application for Medicaid is made
4. The following information shall be included on the Psychiatric Admission Form:
   (a) Recipient information:
      1. Admitting diagnosis
      2. Events leading to hospitalization
      3. History of psychiatric treatment
      4. Current medication
      5. Physician orders

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6. Presenting signs and symptoms

(b) Events leading to present hospitalization

(c) History and physical

(d) Mental and physical capacity

(e) Summary of present medical findings including prognosis and

(f) Plan of care

39.4 Continued Stay Reviews (CSR)

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 30 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.

39.5 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

IMD hospital providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claims processing turnaround
- Ability to immediately correct claim errors
- Online adjustments capability and
- Enhanced access to eligibility information Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing

NOTE:
When an attachment is required, a hard copy UB-04 claim must be submitted.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

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39.5.1 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.

39.5.2 Revenue Codes

Refer to the Alabama UB-04 Manual, published by the Alabama Hospital Association, for a complete list of revenue codes.

39.5.3 Place of Service Codes

Place of service codes do not apply when filing the UB-04 claim form.

39.6 For More Information

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

Resource	Where to Find It
UB-04 Claim Filing Instructions	Chapter 5
Medical Necessity/Medically Necessary Care	Chapter 7
Electronic Media Claims (EMC) Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N

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40 Alabama Coordinated Health Network (ACHN) Primary Care Physician (PCP) and Delivering Healthcare Professional (DHCP) Billing

The Alabama Coordinated Health Network (ACHN) Manual has been developed by the Alabama Medicaid Agency to explain the policies and procedures of the ACHN program. Every effort has been made to present qualified providers a comprehensive guide to basic information concerning program requirements and billing procedures. The policies outlined in this manual are binding upon the provider. Providers should also refer to the Gainwell Provider Insiders, letters, transmittals or ALERTS regarding any updates or changes within this program.

If you have any questions about this program, please contact the Provider Assistance Center at 1 (800) 688-7989.

40.1 ACHN Overview

The ACHN Program will effectively link recipients, providers, and community resources in each of seven (7) newly defined regions to improve health outcomes for Medicaid recipients. Care Coordination within the ACHN is a single program that will allow the Agency and Providers a more effective platform for service delivery and improved quality.

The Networks are located in the Northwest, Northeast, Jefferson and Shelby, Central, East, Southeast, and Southwest regions. The ACHN Regional Map is available on the Medicaid's website at: https://medicaid.alabama.gov/documents/5.0_Managed_Care/5.1_ACHN/5.1.3_ACHN_Providers/5.1.3_ACHN_Regional_Contacts_Revised_10-21-21.pdf

See chart below for a listing of counties for each region:

Region	Counties
Central	Autauga, Butler, Chilton, Crenshaw, Dallas, Elmore, Lowndes, Marengo, Montgomery, Perry, and Wilcox counties
East	Blount, Calhoun, Cherokee, Clay, Cleburne, Coosa, DeKalb, Etowah, Randolph, Talladega, Tallapoosa, and St. Clair counties
Jefferson/Shelby	Jefferson, and Shelby counties
Northeast	Cullman, Jackson, Limestone, Madison, Marshall, and Morgan counties
Northwest	Bibb, Colbert, Fayette, Franklin, Greene, Hale, Lamar, Lauderdale, Lawrence, Marion, Pickens, Sumter, Tuscaloosa, Walker, and Winston counties
Southeast	Barbour, Bullock, Chambers, Coffee, Covington, Dale, Geneva, Henry, Houston, Lee, Macon, Pike, and Russell counties

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Region	Counties
Southwest	Baldwin, Choctaw, Clarke, Conecuh, Escambia, Mobile, Monroe, and Washington counties

See below for ACHN Entities and their contact information:

Region	ACHN	Phone Number (Recipients)	Phone Number (Providers)	Contact Name	Email Address
Central	My Care Alabama Central	1-855-288-8360	1-855-288-8361	Casey Wylie	casey.wylie@MyCareAlabama.org
East	My Care Alabama East	1-855-288-8364	1-855-288-8366	Stephanie Adair	stephanie.adair@mycarealabama.org
Jefferson/ Shelby	Alabama Care Network Mid-State	1-833-296-5245	1-833-296-5245	Whitney Krutulis	wlkrutulis@uabmc.edu
Northeast	North Alabama Community Care	1-855-640-8827	1-855-640-8827	Dana Garrard Stout	dana.garrard@northalcc.org
Northwest	My Care Alabama Northwest	1-855-200-9471	1-855-500-9470	Stacey Copeland	stacy.copeland@MyCareAlabama.org
Southeast	Alabama Care Network Southeast	1-833-296-5246	1-833-296-5246	Kim Eason	keason@uabmc.edu
Southwest	Gulf Coast Total Care	1-833-296-5247	1-833-296-5247	Haleigh Tapscott	hptapscott@uabmc.edu

40.2 ACHN Care Coordination Services

PCP Groups will partner with licensed social workers and nurses from the ACHN who will provide Care Coordination services. Care Coordination referrals may be requested by providers, recipients, or community sources.

The ACHN care coordinators can, among other things:

- Provide services in a setting of the recipient's choice, including provider offices, hospitals, ACHN entity office, public location, or in the recipient's home
- Help manage complex or non-compliant patients
- Perform a screening and assessment of the recipient's needs
- Assist recipients in obtaining transportation or applying for Medicaid
- Help recipients with appointments or appointment reminders
- Coordinate and facilitate referrals
- Educate or assist recipients with medication or treatment plans
- Help recipients seek care in the most appropriate setting (e.g., provider's office versus emergency room)
- Facilitate communication between the patient and care providers
- Help recipients locate needed community services

Recipients with abnormal lead levels, newborn metabolic screenings, and newborn hearing screenings will continue to receive Care Coordination from the Alabama Department of Public Health.

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40.3 Agreements for Primary Care Physicians (PCPs)

40.3.1 *Enrollment*

Primary Care Physicians (PCPs) who want to receive Bonus Payments and ACHN Participation Rates in conjunction with the state's ACHN Program must sign **two** agreements beyond their Medicaid Enrollment. A PCP Group Enrollment Agreement with Medicaid and one agreement with an ACHN is required. The PCP must be enrolled with Medicaid as a Medicaid provider. The provider's enrollment with Medicaid and the ACHN must be fully processed as defined below to ensure bonus payments are made timely. The enrollment agreement must be on file by March 1st, June 1st, September 1st, or December 1st to ensure timely payment. Below are the guidelines for timely processing of agreements:

Medicaid PCP Group Agreement: Providers must complete and submit the agreement directly to Gainwell. The enrollment effective date for the ACHN PCP Group Agreement will the first day of the following month, if the agreement is received and contains no errors prior to the 15th of the month. For agreements received on or after the 15th of the month, the effective date of the enrollment will be the month following the next month.

- **Example 1:** If an agreement is received by Gainwell on December 14th and contains no errors will have an enrollment effective date of January 1st.
- **Example 2:** If an agreement is received by Gainwell on December 19th and contains no errors will have an enrollment effective date of February 1st.
- **Example 3:** If an agreement is received by Gainwell on December 5th but is returned for errors and the returned agreement is sent back to Gainwell, contains no errors, and received on December 16th, the enrollment effective date will be February 1st.

ACHN PCP Network Participation Agreement: In addition to the Medicaid PCP Group Agreement, providers must complete and submit an ACHN PCP Network Participation Agreement to an ACHN to qualify for participation rates and bonus payments. Providers must sign the agreement with the ACHN. On a monthly basis, the ACHNs will notify the Agency of all executed participation agreements. The PCPs and the ACHNs must ensure that the Medicaid Group Billing ID, NPI, Medicaid ID, and name listed on the ACHN PCP Network Participation Agreement is correct and consistent with what the Agency has on the provider's Medicaid file. The provider's file must also be in an active status with the Medicaid Agency. All information submitted must be based on the group level unless the provider is set up as an individual practice. If the information is not correct or consistent, the agreement will not be added to the provider's Medicaid file. In the absence of this agreement, PCPs will not be eligible for participation rates and will not receive bonus payments. If all information communicated to the Agency is correct, the enrollment effective date for the ACHN PCP Network Participation Agreement will be the first day of the following month. Contact the ACHN you intend to participate with to inquire about submission deadlines for the PCP Network Participation Agreement.

The following provider types are eligible to participate in the ACHN program:

- Family Practitioners
- General Practitioners
- Pediatricians
- Internists

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- OB/GYN
- FQHCs and RHCs are eligible to participate with ACHN as a PCP

NOTE:

When in the best interest of a patient, a nontraditional PCP may choose to enroll as a PCP with Medicaid. Other physician types may be considered for PCP participation if willing to meet all contractual and participation requirements.

Alabama Medicaid providers who are interested in participating in the ACHN program must complete and submit an **Application Package** (application and agreement) to:

NOTE:

Out-of-state Providers who are interested in participating in the ACHN program, must be within 30 miles of the Alabama state border.

1. A copy of the PCP Group Enrollment Agreement may be obtained by contacting the Provider Assistance Unit at 1-800-688-7989 or by downloading a copy by visiting www.medicaid.alabama.gov, click ACHN tab, and then click on the Provider section. Please mail completed agreements to:

Gainwell Provider Enrollment Unit
301 Technacenter Drive
Montgomery, AL 36117
or
P.O. Box 241685
Montgomery, AL 36124

AND

2. To obtain the PCP Group Agreement with the ACHN, email the ACHN Regional contact that is listed in the table in section 40.1.

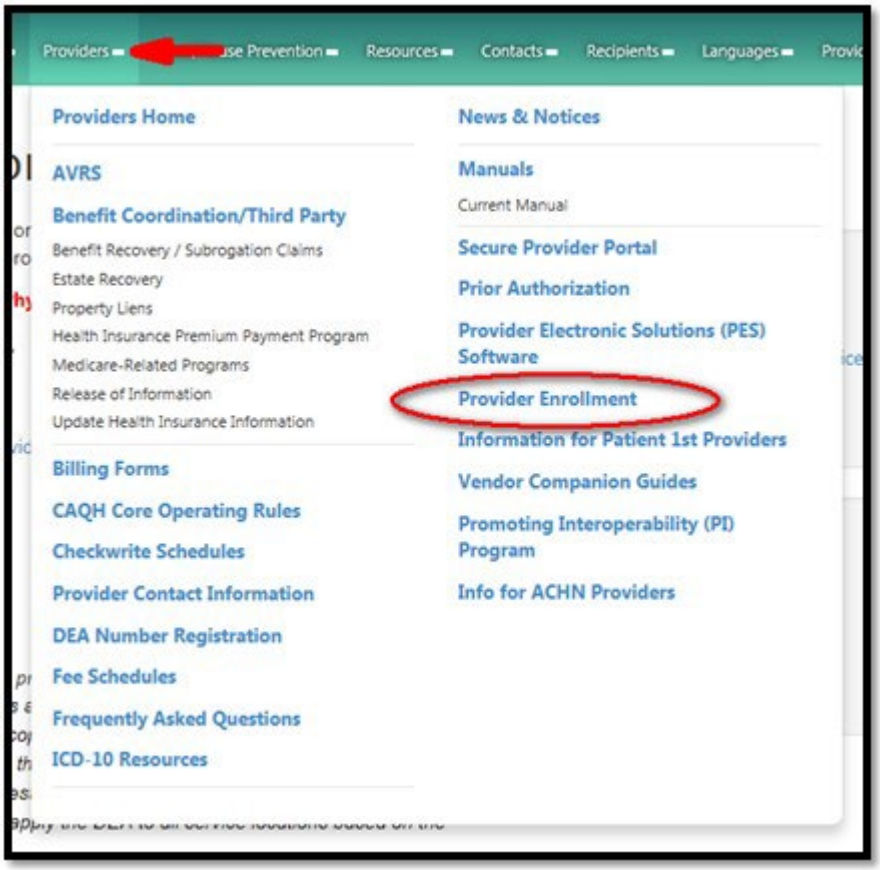
NOTE:

If you are completing the Medicaid PCP Group Agreement for a new enrollment that resulted in being issued a new Medicaid Billing Group ID from a previous enrollment, you must contact the Managed Care Operations (MCO) Division at Medicaid for additional processing. Failure to contact MCO may result in omitted attribution for the new Medicaid Billing Group ID. You may contact MCO at ACHN@medicaid.alabama.gov.

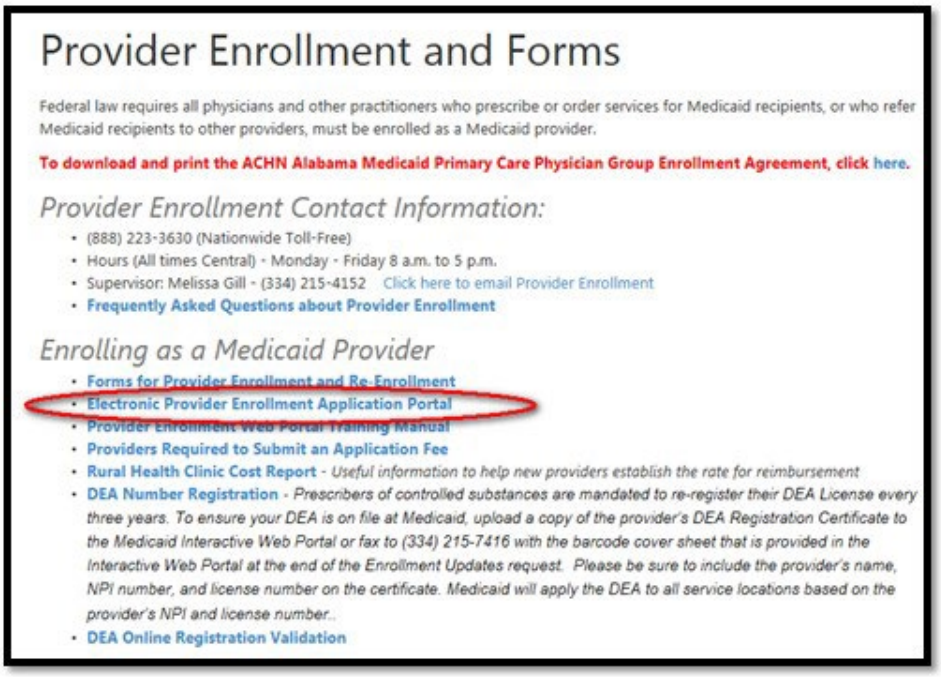
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40.3.2 *Adding a Provider to an Existing ACHN PCP Group Agreement*

For providers who wish to be added to an existing ACHN PCP Group Enrollment, the provider must complete an "Individual within a Group" application. Completing this application will enroll the provider within the group that currently has a PCP Group Agreement on file. The application is submitted electronically via the application portal. This application is also the initial enrollment application for AL Medicaid. The application portal may be found at www.medicaid.alabama.gov. Go to the Providers tab, select Provider Enrollment, and click the hyperlink titled *Electronic Provider Enrollment Application Portal*. For assistance with adding the new provider to your ACHN enrollment, you may contact Provider Enrollment at 1-888-223-3630 or Provider Assistance at 1-800-688-7989.



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40.3.3 *Adding/Updating a Nurse Practitioner's or Physician Assistant's Collaborating Physician*

Nurse practitioners (NPs) and physician assistants (PAs) must be collaborating with an active Medicaid enrolled physician to participate in the Medicaid program. The NP's and PA's collaborating physician must align with records from the Alabama Board of Medical Examiners (ALBME). In addition, the NP or PA, the group, and the collaborating physician must all be linked under the same group enrollment NPI. Inconsistent or incorrect collaborating physician information on the NP's or PA's Medicaid file may cause claims to deny. To add or update the collaborating physician on the NP's or PA's Medicaid file, a request must be submitted on letterhead requesting the addition or update. The letter must include the NP's name, NPI, Medicaid ID (for each location), the collaborating physician's name, collaborating physician's NPI, collaborating physician's Medicaid ID, and signature. A copy of the current collaborating license must be attached to the letter. The letter and license must be submitted through the secure web portal. For assistance with updating the NP's or PA's collaborating physician, contact Provider Enrollment at 1-888-223-3630.

40.4 PCP Determination

To be identified as a PCP a provider must be one of the following:

- A Teaching Facility
- A County Health Department
- A PCP group or individual participating with an ACHN
- An OB/GYN
- An FQHC
- An RHC

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40.5 Requirements for PCP Active Participation with the ACHN

PCP requirements for "active participation" with one of the seven ACHNs are described below:

- In person attendance over a 12-month period to at least two quarterly medical management meetings and one webinar/facilitation exercise with the ACHN's medical director (one PCP or nurse practitioner/physician assistant from the group may attend to meet attendance requirements)
- Engagement in ACHN initiatives centered around Quality Measures
- Data review with the ACHN to help achieve Agency and ACHN Quality goals
- Engagement as appropriate in the ACHN's multidisciplinary care team and the development of an individualized and comprehensive care plan

If a PCP stops actively participating or terminates their agreement with the ACHN they signed the original agreement with, then the PCP Group must sign another agreement to actively participate with a different ACHN to continue receiving Participation Rates and Bonus payments.

In the absence of these agreements, PCP Groups will not be eligible to receive enhanced Participation Rates or Bonus Payments for Quality, Cost Effectiveness, and Patient Centered Medical Home (PCMH) recognition. If a provider chooses not to engage in active participation, they will receive regular fee-for-service rates and, if eligible, current BUMP rates.

40.6 Provider Directory

A Provider Directory is available via the Medicaid Web site to all providers and recipients to assist in selecting physicians/clinics in their regions. The Provider Directory can be used by recipients to help locate a doctor. The Provider Directory can also be used by providers to obtain contact information. Providers and recipients can filter to search by name, city, county, specialty or a combination of all. The Provider Directory is mobile and print friendly.

40.7 PCP Group/ PCP Disenrollment

The Agreement to participate in the ACHN program may be terminated by either the PCP Group or Agency, with cause or by mutual consent; upon at least 30 days written notice and will be effective on the first day of the month, pursuant to processing deadlines.

If a PCP dies, moves out of the service area, or loses Medicaid and/or **ACHN** provider status, the Agency must be notified by submitting a Disenrollment Form within 30 days of the PCP's departure.

NOTE:

For all Disenrollment situations listed above, a Disenrollment Request Form must be completed. You may obtain the form at: http://medicaid.alabama.gov/content/9.0_Resources/9.4_Forms_Library/9.4.16_Provider_Enrollment_Forms.aspx

Disenrollment forms must be electronically uploaded to the Web Portal in PDF format. Failure to provide a 30-day notice may preclude future participation opportunities.

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40.8 PCP Group Responsibilities, Functions, and Duties

In order to participate as a PCP Group, the following requirements must be met. Detailed information is provided on specific requirements in subsequent sections.

The PCP Group shall comply with all applicable federal and state statutes and regulations, and all amendments thereto, that are in effect when the ACHN Agreement became into effect during the term of the ACHN Agreement. This includes, but is not limited to, the Alabama State Plan and Title 42 of the Code of Federal Regulations (CFR).

The PCP Group agrees to the following:

- Enter a Participation Agreement with an Entity;
- Actively Participates (refer to section 40.5) with an Entity;
- Each PCP Group physician must be a licensed physician enrolled in the Alabama Medicaid Program who has not been sanctioned.
- Be listed as a Group in the ACHN Directory for the purpose of providing care to recipients and managing their health care needs as agreed in the ACHN agreement.
- Provide services to recipients pursuant to the terms of the ACHN Agreement.
- Provide or arrange for primary care coverage, twenty-four (24) hours per day and seven (7) days per week as defined in Attachment A of the PCP Group Agreement, for services, consultation, management or referral, and treatment for emergency medical conditions. Automatic referral to the hospital emergency department for services does not satisfy this requirement. The PCP Group must have at least one telephone line that is answered by the office staff during regular office hours.
- Provide EPSDT preventive care screenings to Medicaid eligible children age birth through 20. PCP Groups serving this population who do not provide EPSDT services are required to sign an agreement with another provider to provide EPSDT services. PCP Groups must retain a copy of this agreement in their files and must ensure that their records include information regarding the extent of these services.
    - Provide hospital admissions. (Refer to section 40.8.1: Hospital Admitting Privileges Requirement)
    - Maintain a unified patient medical record for each recipient following the medical record documentation guideline as defined by Medicaid Policy in Rule No. 560-X-1-.21 of the Alabama Medicaid Administrative Code and policy.
    - Promptly arrange referrals for medically necessary health care services that are not provided directly and document referral for specialty care in the medical record. Provide the NPI to the consulting provider.
    - Transfer the recipient medical record to the receiving PCP Group at the request of the new PCP Group and as authorized by the recipient within thirty (30) days of the date of the request. Recipients cannot be charged for copies of medical records.

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NOTE:

Patients must request their records be transferred to the new PCP Group and must not be charged a fee for this service.

- Authorize care for the recipient or see the recipient based on the standards of appointment availability as defined by policy.
- Refer for a second opinion as defined by policy.
- Review and use all recipient utilization, quality improvement, and other reports provided by the Agency and/or Entity for the purpose of practice level utilization management, quality of care improvement, and advise the Agency of errors, omissions, or discrepancies.
- Participate with Agency utilization management, quality assessment, complaint and grievance, and administrative programs.
- Provide the Agency or its duly authorized representatives and appropriate Federal Agency representatives unlimited access (including onsite inspections and review) to all records relating to the provision of services under the PCP Group agreement as required by Medicaid policy in Rule No. 560-X-1-.21 of the Alabama Medicaid Administrative Code and 42 C.F.R. § 431.107.
- Maintain reasonable standards of professional conduct and provide care in conformity with generally accepted medical practice following national and regional clinical practice guidelines.
- Notify the Agency of all changes to information provided on the initial application for participation in the ACHN Program. If such changes are not reported within thirty (30) days of change, future participation may be limited.
- Give written notice of termination of ACHN Agreement to each recipient who received his or her primary care from, or was seen on a regular basis, by the PCP Group within thirty (30) days after receipt of the termination notice or within thirty (30) days of notice of termination.
- Retain records in accordance with requirements of Rule No. 560-X-1-.21 of the Alabama Medicaid Administrative Code after the final payment is made and all pending matters closed, plus additional time if an audit, litigation, or other legal action involving the records is started before the original retention period ends.
- Comply with all Federal and State laws and regulations including Title VI of the Civil Rights Act of 1964, Title IX of the Education of Amendments of 1972 (regarding education programs and activities), the Age Discrimination Act of 1975, the Rehabilitation Act of 1973, and the Americans with Disabilities Act.
- Receive prior approval from the Agency of any ACHN specific, or education materials prior to distribution.

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- Make oral interpretation services available free of charge to each potential enrollee and enrollee. This applies to all non-English languages.

NOTE:

Recipients can obtain assistance with language interpretation by calling the Recipient Call Center at 1(800) 362-1504.

- Provide the Agency with at least thirty (30) days prior notice of PCP Group disenrollment, change in practice site, Medicaid Group Billing ID, or NPI changes to allow for notification to recipients. Failure to provide thirty (30) day notice may preclude future participation.
- Have the ability to provide comprehensive whole-person care that includes a comprehensive health care assessment (including mental health and substance use), coordination and access to preventive and health promotion services, including prevention of mental illness and substance use disorders, medical and health care services informed by evidence-based clinical practice guidelines, mental health, substance abuse, and developmental services, and chronic disease management, including self-management support to individuals and their families, and interventions.
- Have the ability to provide continuity of personal clinician assignment and clinician care, organization of clinical information, clinical information exchange, and specialized care settings.
- Have the capacity to provide culturally appropriate, and person- and family-centered services, coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services, and provide a positive experience of care.
- Upon termination of the Agreement, the PCP Group must supply all information necessary for reimbursement of outstanding Medicaid claims.

The PCP Group is prohibited from the following:

- Discriminating against Recipients on the basis of health status or the need for health care services.
- Discriminating against Recipients on the basis of race, color, or national origin and will refrain from using any policy or practice that has the effect of discriminating on the basis of race, color, or national origin.
- Refrain from knowingly engaging in a relationship with the following:
  1. An individual who is debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549; or
  2. An individual who is an affiliate, as defined in the Federal Acquisition Regulation.

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Note: The relationship is described as follows:

a. As a director, officer, partner of the PCP Group; or

b. A person with beneficial ownership of more than five percent (5%) or more of the PCP Group's equity; or

c. A person with an employment, consulting or other arrangement with the PCP Group for the provision of items and services which are significant and material to the PCP Group's contractual obligation with the Agency.

40.8.1 *Hospital Admitting Privileges Requirement*

- PCP Group is required to establish and maintain hospital admitting privileges or have a formal arrangement with a hospitalist group or another physician or group for the management of inpatient hospital admissions that addresses the needs of all recipients. If a Group does not admit recipients, then the Hospital Admitting Agreement must be submitted to the Agency to address this requirement for participation. If the PCP Group has entered a formal arrangement for inpatient services, this form must be completed by both parties, and the applicant must submit the original form with the Application for enrollment or resubmit within ten (10) days of when a change occurs regarding the PCP Group's management of inpatient hospital admissions.
- A formal arrangement is defined as a voluntary agreement between the PCP Group and the agreeable physician/group. The agreeable party is committing in writing to admit and coordinate medical care for the recipient throughout the inpatient stay. Admitting privileges or the formal arrangement for inpatient hospital care must be maintained at a hospital that is within a forty-five (45) minutes' drive time from the PCP Group's practice. If there is no hospital that meets the above geographical criteria, the hospital geographically closest to the PCP Group's practice will be accepted.
- Exception may be granted in cases where it is determined the benefits of a PCP Group's participation outweigh the PCP Group's inability to comply with this requirement.

See Attachment B of Alabama Medicaid Primary Care Physician Group Enrollment Agreement for more information on the Hospital Admitting Requirements.

40.8.2 *24/7 Coverage Requirement*

- The PCP Group must provide recipients with after-hours coverage. It is important that recipients be able to contact their PCP Group to receive instruction or care at all times, so that care will be provided in the most appropriate manner to the recipient's condition. After hours coverage must be available 24 hours a day every day of the year. The PCP Group can meet this requirement through a variety of methods. To qualify as an ACHN PCP Group, one of the following must be met:

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- The after-hours telephone number must connect the patient to the PCP Group's physician or an authorized medical practitioner.

- The after-hours telephone number must connect the recipient to a live voice call center system or answering service who will either direct the recipient to the appropriate care site or contact the PCP Group's physician or PCP Group's authorized medical practitioner. If the PCP Group's physician or authorized medical practitioner is contacted, then the recipient should receive instructions within one (1) hour.

- The after-hours telephone number can connect to a hospital if the PCP Group has standing orders with the hospital to direct recipients to the appropriate care site. (For example, if the recipient's symptoms are such that the recipient can be seen the next morning, the hospital should direct the recipient to contact the PCP Group in the morning to make an appointment).

An office telephone line that is not answered after hours or answered after hours by a recorded message instructing recipients to call back during office hours or to go to the emergency department for care is not acceptable. It is not acceptable to refer recipients to the PCP Group's home telephone if there is not a system in place as outlined above to respond to calls. Systems designed to refer all requests to go physically to the Emergency Room are not acceptable. Failure to comply with the 24/7 coverage requirements may affect future participation opportunities. See Attachment A of Alabama Medicaid Primary Care Physician Group Enrollment Agreement for more information on the 24/7 Coverage Requirements.

40.8.3 *EPSDT Requirement*

For recipients of Medicaid, birth to age 21, the EPSDT Screening is a comprehensive preventive service at an age appropriate recommended schedule. It is the only reimbursable preventive medical service for this age group. There are numerous components of the EPSDT, all of which are required in the Federal Early Periodic Screening Diagnosis Treatment (EPSDT) program. All age appropriate components must be performed at the time of a screening exam. These components are listed and described in Appendix A of the Alabama Medicaid Provider Manual.

PCP's are requested to either perform or make arrangements for EPSDT screenings. The PCP is responsible for ensuring that age appropriate EPSDT screenings are provided. If a PCP cannot or chooses not to perform the comprehensive EPSDT screenings, the PCP may authorize another provider to perform the screenings for enrollees in the birth to 21 age group.

If the PCP enters into an agreement with a screener in order to meet this ACHN requirement for participation, the agreement containing the original signatures of the PCP or the authorized representative and the screener or an authorized representative must be submitted within the enrollment application. The PCP must keep a copy of this agreement on file. If this agreement is executed after enrollment a copy must be submitted within ten (10) days of execution.

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The agreement can be entered into or terminated at any time by the PCP or the screener. The Agency and Gainwell must be notified immediately of any change in the status of the agreement.

If there is an agreement between the PCP and a Screener to provide EPSDT services, the PCP agrees to:

- Refer patients for EPSDT screenings. If the patient is in the office, the physician/office staff will assist the patient in making a screening appointment with the Screener within ten (10) days.
- Maintain, in the office, a copy of the physical examination and immunization records as part of the patient's permanent record.
- Monitor the information provided by the Screener to assure that children in the ACHN program are receiving immunizations as scheduled and counsel patients appropriately if found in noncompliance with well child visits or immunizations.
- Review information provided by the Screener to coordinate any necessary treatment and/or follow-up care with patients as determined by the screening.
- Notify the Agency and Gainwell immediately of any changes to this agreement.

The Screener must agree to:

- Provide age appropriate EPSDT examinations and immunizations within sixty (60) days of the request for patients who are referred by the PCP or are self-referred.
- Send EPSDT physical examination and immunization records within 30 days to the PCP.
- Notify the PCP of significant findings on the EPSDT examination or the need for immediate follow-up care within 24 hours. Allow the PCP to direct further referrals for specialized testing or treatment.
- Notify the Agency and Gainwell immediately of any changes to this agreement.

40.9 Standards of Appointment Availability and Office Wait Times

The PCP Group must conform to the following standards for appointment availability:

- Emergency care – immediately upon presentation or notification
- Urgent care – within 24 hours of presentation or notification
- Routine sick care – within 3 days of presentation or notification
- Routine well care – within 90 days of presentation or notification (15 days if pregnant)

The PCP Group must conform to the following standards for office wait times:

- Walk-ins – within two hours or schedule an appointment within the standards of appointment availability

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- Scheduled appointment – within one hour
- Life-threatening emergency – must be managed immediately

If these standards cannot be met due to extenuating circumstances, then the recipient should be informed within a reasonable amount of time and given an opportunity to reschedule the appointment.

40.10 PCP Medical Records Guidelines

Medical records should reflect the quality of care received by the recipient. However, many times medical records documentation for the level of care provided varies from provider to provider. Therefore, in order to promote quality and continuity of care, a guideline for medical record keeping has been established. All ACHN PCP Groups must implement the following guidelines as the standards for medical record keeping:

1. Each page, or electronic file in the record, contains the recipient's name or recipient's Medicaid identification number.
2. All entries are dated.
3. All entries are identified as to the author.
4. The record is legible to someone other than the writer, including the author.
5. Medication allergies and adverse reactions are prominently noted and easily identifiable as well as the absence of allergies.
6. Personal and demographic data is recorded and includes age, sex, address, employer, home and work telephone numbers, and marital status.
7. Past medical history is easily identified including serious accidents, operations, and illnesses. For children, past medical history relates to prenatal care and birth.
8. There is a completed immunization record.
9. Diagnostic information, medication, medical conditions, significant illnesses, and health maintenance concerns are recorded in the medical record.
10. Notation concerning smoking, alcohol, and other substance abuse is present.
11. Notes from consultations are in the record. Consultation, lab, and X-ray reports filed in the chart have the ordering provider's initials or other documentation signifying review. Consultation and significantly abnormal lab and imaging results have an explicit notation in the record of the follow-up plans.
12. Emergency care is documented in the record.
13. Discharge summaries are included as part of the medical record for hospital admissions.
14. Documentation of individual encounters that provide adequate evidence of appropriate history, physical examination, diagnosis, diagnostic test, therapies, and other prescribed regimen, follow-up care, referrals and results thereof, and all other aspects of patient care, including ancillary services.

40.11 Recipient Education

Recipient education will be an integral part of the ACHN Program to help the recipients understand the program and their responsibilities. It is also imperative to stress the importance of contacting the ACHN and/or the Recipient Call Center (RCC) (1-800-362-1504) number anytime there is a question.

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In addition, as the coordinator of care, it is important for PCP Groups to be actively involved in patient education. PCP Groups are encouraged to contact all new recipients by telephone or in writing.

Providers should address the following subjects with each new recipient:

- The PCP Group's requirement to provide medical advice and care 24 hours per day, 7 days per week and the preferred method for contacting the PCP Group
- The requirement that the recipient must contact the PCP Group before going to the emergency room unless the recipient feels that his/her life or health is in immediate danger
- The importance of regular preventive care visits such as Well Child Check-ups EPSDT screenings for children, immunizations, check-ups, mammography, cholesterol screenings, adult health assessments, and diabetic screenings
- The availability of additional information for recipients from the ACHN or the Agency's Recipient Call Center

40.12 Agreement Violation Provisions

Failure to meet the terms outlined in the ACHN PCP Group Enrollment Agreement or other provisions of the Medicaid Program governed under Social Security Act Sections 1932, 1903(m) and 1905(t) may result in the following actions by the Agency:

- Referral to the Agency's Program Integrity for investigation of potential fraud
- Referral to the Board of Medical Examiners or other appropriate licensing board
- Termination of the PCP Group from the Alabama Medicaid Program

40.13 BMI Requirement

Primary Care Physicians (PCPs), nurse practitioners and physician assistants collaborating with a PCP, a PCP group or individual participating with an ACHN, Federally Qualified Health Centers (FQHCs), Rural Health Centers (RHCs), Public Health Departments, and OB/GYNs that bill procedure codes 99201-99205, 99211-99215, and 99241-99245 must include an annual BMI diagnosis on the claim or the claim will be denied. EPSDT procedure codes 99382-99385 and 99392-99395 must also include an annual BMI diagnosis on the claim or the claim will be denied. If a BMI has been reported on a recipient for the current calendar year (January 1 – December 31), the claim will pay without a new BMI. If the BMI has not been reported on the recipient for the current calendar year, a BMI will be required for the claim to pay. For additional information on changes to the BMI Requirement, see the *Changes to BMI Requirement* ALERT on the Alabama Medicaid Agency's website.
Medicaid ALERTs: https://medicaid.alabama.gov/alerts.aspx

BMI Requirement during Telemedicine/Telehealth Visits

The BMI will be required for all visits including the telemedicine visits. (Refer to Chapter 112, Telemedicine Services, for general benefit information and limitations.)

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The table below provides a description of procedure codes and ICD-10 codes that require a percentile on the CMS 1500 claim form for **recipient's age 3-19 years**:

Procedure Code Description	ICD-10 Diagnosis Code Description for Ages 3-19
99201 Office/Outpatient Visit New 99202 Office/Outpatient Visit New 99203 Office/Outpatient Visit New 99204 Office/Outpatient Visit New 99205 Office/Outpatient Visit New 99211 Office/Outpatient Visit Est 99212 Office/Outpatient Visit Est 99213 Office/Outpatient Visit Est 99214 Office/Outpatient Visit Est 99215 Office/Outpatient Visit Est 99241 Office Consultation 99242 Office Consultation 99243 Office Consultation 99244 Office Consultation 99245 Office Consultation 99382 EPSDT New Patient 99383 EPSDT New Patient 99384 EPSDT New Patient 99385 EPSDT New Patient 99392 EPSDT Est Patient 99393 EPSDT Est Patient 99394 EPSDT Est Patient 99395 EPSDT Est Patient	Z6851 BMI Pediatric, Less Than 5th Percentile for Age Z6852 BMI Pediatric, 5th Percentile to Less Than 85% for Age Z6853 BMI Pediatric, 85% To Less Than 95th Percentile for Age Z6854 BMI Pediatric, Greater Than or Equal To 95% for Age

NOTE:

For Pediatric BMI reporting: The same BMI code may be appended to the claim until the next well child check (where a BMI is typically determined) unless the physician considers the clinical need for a BMI redetermination sooner than the next well child check.

The table below provides a description of procedure codes and ICD-10 codes that require a BMI on the CMS 1500 claim form for **recipients age 20 and older**:

Procedure Code Description	ICD-10 Diagnosis Code Description For Ages 20 and Older
99201 Office/Outpatient Visit New 99202 Office/Outpatient Visit New 99203 Office/Outpatient Visit New 99204 Office/Outpatient Visit New 99205 Office/Outpatient Visit New 99211 Office/Outpatient Visit Est 99212 Office/Outpatient Visit Est 99213 Office/Outpatient Visit Est 99214 Office/Outpatient Visit Est	Z681 Body Mass Index (BMI) 19 Or Less, Adult Z6820 Body Mass Index (BMI) 20.0-20.9, Adult Z6821 Body Mass Index (BMI) 21.0-21.9, Adult Z6822 Body Mass Index (BMI) 22.0-22.9, Adult Z6823 Body Mass Index (BMI) 23.0-23.9, Adult

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99215	Office/Outpatient Visit Est	Z6824	Body Mass Index (BMI) 24.0-24.9, Adult
99241	Office Consultation	Z6825	Body Mass Index (BMI) 25.0-25.9, Adult
99242	Office Consultation	Z6826	Body Mass Index (BMI) 26.0-26.9, Adult
99243	Office Consultation	Z6827	Body Mass Index (BMI) 27.0-27.9, Adult
99244	Office Consultation	Z6828	Body Mass Index (BMI) 28.0-28.9, Adult
99245	Office Consultation	Z6829	Body Mass Index (BMI) 29.0-29.9, Adult
		Z6830	Body Mass Index (BMI) 30.0-30.9, Adult
		Z6831	Body Mass Index (BMI) 31.0-31.9, Adult
		Z6832	Body Mass Index (BMI) 32.0-32.9, Adult
		Z6833	Body Mass Index (BMI) 33.0-33.9, Adult
		Z6834	Body Mass Index (BMI) 34.0-34.9, Adult
		Z6835	Body Mass Index (BMI) 35.0-35.9, Adult
		Z6836	Body Mass Index (BMI) 36.0-36.9, Adult
		Z6837	Body Mass Index (BMI) 37.0-37.9, Adult
		Z6838	Body Mass Index (BMI) 38.0-38.9, Adult
		Z6839	Body Mass Index (BMI) 39.0-39.9, Adult
		Z6841	Body Mass Index (BMI) 40.0-44.9, Adult
		Z6842	Body Mass Index (BMI) 45.0-49.9, Adult
		Z6843	Body Mass Index (BMI) 50-59.9, Adult
		Z6844	Body Mass Index (BMI) 60.0-69.9, Adult
		Z6845	Body Mass Index (BMI) 70 or Greater, Adult

Some specialties are exempt from the BMI requirement. The table below lists provider specialties that are excluded from the BMI requirement:

Spec	Description	Spec	Description
021	Cardiac Electrophysiology	332	Otologist, Laryngologist, Rhinologist
023	Sports Medicine	337	Plastic Surgeon
180	Optometrist	339	Psychiatrist
310	Allergist	340	Pulmonary Disease Specialist
311	Anesthesiologist	341	Radiologist
312	Cardiologist	342	Thoracic Surgeon
313	Cardiovascular Surgeon	343	Urologist
314	Dermatologist	750	Colon and Rectal Surgery

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317	Gastroenterologist	760	EENT
319	General Surgeon	770	Endocrinologist
321	Hand Surgeon	780	Hematology
324	Nephrologist	790	Infectious Disease
325	Neurological Surgeon	810	Orthopedic
326	Neurologist	830	Rheumatology
329	Oncologist	922	Perinatologist High-Risk Pregnancy
331	Orthopedic Surgeon		

NOTE:
Pregnant women with a pregnancy diagnosis code are excluded from the BMI requirement.

40.14 Referral Requirements

PCP to PCP referrals are not required. Effective August 1, 2021, under the ACHN program for specialty services, a referral from a PCP or an ACHN Network is no longer required (with the exception of Lock-in and EPSDT programs). EPSDT referrals will continue to be required. (Refer to Appendix A for EPSDT referral requirements.)

40.14.1 *Referrals for Specialty Providers Associated with Teaching Facilities*

Alabama Medicaid providers who are considered teaching specialty providers may provide services to Medicaid recipients without a Primary Care Physician (PCP) referral. Medicaid claims can be processed for payment without a referral, however, the absence of communication between PCPs and specialists may hinder optimal coordination of medical care. Therefore, communication is encouraged. The Early Periodic Screening, Diagnosis, and Treatment (EPSDT) referral remains in place to assist with managing the fourteen-office visit limit. For more information regarding referrals for Specialty Providers Associated with Teaching Facilities, you may access the Teaching Facility Referrals in the ACHN one-pager with the following link: https://medicaid.alabama.gov/documents/5.0_Managed_Care/5.1_ACHN/5.1.3_ACHN_Providers/5.1.3_Teaching_Facility_Referrals_ACHN_10-31-19.pdf.

40.14.2 *Referral Form*

All referrals must be documented on the *Alabama Medicaid Agency Referral Form (Form 362). (Applies to EPSDT and Lock-in programs)* Please refer to the Appendix A of the Medicaid Provider Manual for further information on EPSDT.

40.14.3 *EPSDT Screening Referrals*

Please refer to the Appendix A of the Medicaid Provider Manual for further information on EPSDT.

40.15 Override Requests

In extenuating circumstances, on a case-by-case basis, and after thorough review, Medicaid may determine that an override may be prudent in some situations. There may also be instances where a BMI cannot be determined (e.g. wheelchair bound recipients). In these cases, providers may request a BMI override using the **PCP**

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Override Request form to obtain payment. A copy of the **PCP Override Request form** is in Appendix E of the Medicaid Provider Manual. An Override Request Form and a clean Red Drop Ink claim form (CMS Form 1450 (UB-04) or CMS Form 1500) must be submitted to the Network Provider Assistance Unit by mail within 90 days of the date of service. CMS Form 1450 (UB-04) or CMS Form 1500 must be an original and must be signed or the override request will not be approved and returned to the provider. Requests will be evaluated within 60 days of receipt. Overrides will not be approved for well visits.

The override request must be mailed to:

Alabama Medicaid Agency
Network Provider Assistance Unit
501 Dexter Avenue
P.O. Box 5624
Montgomery, AL 36103-5624

40.16 Reimbursements and Payments to PCP Groups

PCP Groups are eligible to earn higher payments for 15 Evaluation and Management (E&M) codes if they participate with the ACHNs. This higher payment is called the ACHN Participation Rate and includes the following E&M codes: 99201-99205, 99211-99215, and 99241-99245. Nurse Practitioners and Physician Assistants who are enrolled in the PCP Group will receive 80% of the physician rate for these E&M codes. FQHCs and RHCs are excluded from this payment as they receive encounter rates.

All PCPs (including FQHCs and RHCs) participating with the ACHN will initially qualify to receive Bonus Payments for meeting Quality, Cost Effectiveness, and Patient Centered Medical Home (PCMH) recognition. Denote: This paragraph dates back to 2019 and only refers/applies to PCP groups enrolled at the startup of the ACHN program. Thereafter, all PCP groups must qualify to receive bonus payments offered within the ACHN program.

Definitions for Different Rates PCPs may earn:

Fee-For-Service Rates: This is the base fee-for-service rate a physician will receive for E&M codes if he/she chooses not to participate with the ACHN.

BUMP Rates: PCPs must qualify for the BUMP rates as described by the Physician Program. Follow the same attestation process as currently exists. (Refer to Chapter 28, Physician Program, for additional information.)

Participation Rates: Participation Rates are higher than BUMP rates and will be paid to providers that actively participate with the ACHN (refer to section 40.5). FQHCs and RHCs will not receive these rates, however, but will continue to receive encounter rates.

Bonus Payments: These payments will be made to all participating providers (including FQHCs and RHCs) during the start-up phase of the program and will be based on the attribution of recipients to providers (refer

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to section 40.19). After the start-up phase, bonuses will be based on performance. Nurse Practitioners, Physician Assistants, and Nurse Midwives will receive 80% of the physician rate for these Bonus Payments. These Bonus Payments also apply to FQHCs and RHCs.

NOTE:

Bonus payments will be made on the second or third checkwrite of the 1st month of the quarter (January, April, July, and October) unless otherwise noted.

Payment Types and Payment Cycles are described in the table below:

Type of Payment	When Paid
Fee-For-Service	Every checkwrite
ACHN Participation Rate	Every checkwrite
Bonus Payment	The second or third checkwrite of the first month of the quarter.
BUMP Payments	Every checkwrite

The table below shows four different scenarios for PCP Group Payments:

Alabama Medicaid Agency

ACHN Primary Care Physician Payment Chart

Primary Care Physician Scenarios	Base FFS Rates	Bump Rates	Participation Rates	Bonus Payments
PCP Scenario 1: PCPs not eligible for Bump Rates & not participating with ACHN	√	X	X	X
PCP Scenario 2: PCPs not eligible for Bump Rates & participating with ACHN	√	X	√	√
PCP Scenario 3: PCPs eligible for Bump Rates & not participating with ACHN	X	√	X	X
PCP Scenario 4: PCPs eligible for Bump Rates & participating with ACHN	X	√	√	√

The table below further describes the four different PCP Group payment scenarios listed above:

EXAMPLE
Participation Rate (PR) = Enhanced Rates for fifteen E & M codes
PCP Scenario 1 Example: Receive only Base FFS Rates for all codes, including the fifteen PR codes
PCP Scenario 2 Example: Receive PR for the fifteen E&M codes, FFS Rates for all other codes, and Bonus Payments
PCP Scenario 3 Example: Receive Bump Rates only (no Participation Rates or Bonus Payments)
PCP Scenario 4 Example: Receive PR for the fifteen E & M codes, Bump Rates for all other codes, and Bonus Payments

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BUMP Rates vs. ACHN Participation Rates are described in the table below:

BUMP Rates vs. Participation Rates				
Procedure	**Procedure Description**	**BUMP Rate**	**ACHN Participation Rate**	**Amount Increase**
99201	OFFICE/OUTPATIENT VISIT NEW	$40.04	$42.00	$1.96
99202	OFFICE/OUTPATIENT VISIT NEW	$69.27	$73.00	$3.73
99203	OFFICE/OUTPATIENT VISIT NEW	$100.52	$107.00	$6.48
99204	OFFICE/OUTPATIENT VISIT NEW	$155.25	$166.00	$10.75
99205	OFFICE/OUTPATIENT VISIT NEW	$194.18	$210.00	$15.82
99211	OFFICE/OUTPATIENT VISIT EST	$18.46	$19.00	$0.54
99212	OFFICE/OUTPATIENT VISIT EST	$40.36	$41.00	$0.64
99213	OFFICE/OUTPATIENT VISIT EST	$68.17	$72.00	$3.83
99214	OFFICE/OUTPATIENT VISIT EST	$100.91	$108.00	$7.09
99215	OFFICE/OUTPATIENT VISIT EST	$135.59	$146.00	$10.41
99241	OFFICE CONSULTATION	$45.45	$46.00	$0.55
99242	OFFICE CONSULTATION	$85.87	$88.00	$2.13
99243	OFFICE CONSULTATION	$117.58	$122.00	$4.42
99244	OFFICE CONSULTATION	$175.38	$184.00	$8.62
99245	OFFICE CONSULTATION	$214.62	$226.00	$11.38

40.17 Urban/Rural Counties (for Providers)

A map showing urban and rural counties for providers may be accessed on the Medicaid website at: www.medicaid.alabama.gov, then select the ACHN tab, ACHN Providers, Medicaid's Designated Urban and Rural Map.

40.18 Agency Monitoring

Active Participation requirements will be monitored monthly by the Agency and the ACHN. The Agency will remove a PCP or PCP Group from the ACHN for not meeting requirements. Before a PCP Group is removed from ACHN participation, the Agency will confirm with the ACHN and the PCP Group that the Group did not meet the requirements.

40.19 Attribution

Under the ACHN Program, Medicaid recipients will be attributed to physicians based on historical claims data utilization. ***To determine the provider types that are identified as PCPs, refer to section 40.4: PCP Determination.*** Reference Rule No. 560-X-37-.09, "Attribution under the Alabama Coordinated Health Network Program." Attribution is the process that will be used to associate a Medicaid recipient to the PCP Group that provides primary care to that recipient. Attribution is a critical factor in determining distribution of Bonus Payments among eligible providers. On a quarterly basis, the Medicaid Agency

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will determine attribution for each Medicaid recipient under the ACHN Program in accordance with the following process:

- The Medicaid Agency will review the previous two-year history of provider visit utilization for each Medicaid recipient. Utilization will consider both preventive visits and regular office visits.
- Points will only be awarded for claims that are in a paid status before the end of the attribution run period.
- If a specialist group has the highest number of points, then the specialist group will be attributed the Medicaid recipient; however, a specialist group shall not be eligible to receive the bonus payments described above.
- The Medicaid Agency will review the previous 12-month history of filled prescriptions for chronic care conditions for each Medicaid recipient.
- The point values described below associated with the visits and prescriptions will be assigned to the individual doctor that performed the service. The individual PCP scores will be combined to form the PCP Group's total point score for each patient.
- PCP Groups will receive points based on the number of preventive visits (CPT 99381-99387, 99391-99397) and regular office visits (CPT 99201-99205, 99211-99215) conducted by the PCP Group. Points will be awarded as follows:

	Type of Visit	0-6 Months Ago	6-12 Months Ago	12-18 Months Ago	18-24 Months Ago
PCP	Standard	4	4	2	2
	Preventative	8	4	4	2
Non-PCP Specialist	Standard	2	2	1	1
	Preventative	4	2	2	1

- PCP Groups will receive points based on the number of prescriptions filled for chronic care conditions. For the purposes of this rule, prescriptions for chronic care conditions shall mean more than one prescription filled for a chronic condition (e.g., asthma) and must correspond to an office visit from the prescribing provider within the previous two (2) years.
- The PCP Group with the highest number of points will have the Medicaid recipient attributed to that PCP Group. The Medicaid recipient must have met criteria for the ACHN Program for three (3) out of the previous twenty-four (24) months to be attributed.

40.19.1 *Attribution Report*

The attribution report is a listing of attributed recipients issued to providers that have recipients attributed to their group. The report is produced quarterly after the attribution process is complete. The report will list new attributions, continuing attributions, and terminated attributions. The report is available to providers from the Alabama Medicaid Interactive Services Web Site (web portal).

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The following table lists the timeframe in which attribution reports will be available via the secure web portal for fiscal year 2024:

Attribution Period	Attribution Run Month	Attribution Reports Available
October 1, 2023 – December 31, 2023 (Quarter 1)	August 2023	First or second week of September 2023
January 1, 2024 – March 31, 2024 (Quarter 2)	November 2023	First or second week of December 2023
April 1, 2024 – June 30, 2024 (Quarter 3)	February 2024	First or second week of March 2024
July 1, 2024 – September 30, 2024 (Quarter 4)	May 2024	First or second week of June 2024

Each quarter, the provider group can obtain a listing of new recipients, continuing recipients, and terminated recipients. The listing will include the recipient's demographic information, Medicaid number, aid category, and county code. The recipient status will be noted at the top of each page as new, continuing or terminated.

- New Attributions– recipients that are new to your attribution.
- Continuing Attributions – recipients that have been previously attributed and continue to be attributed to the PCP.
- Terminated Attributions – recipients that have been deleted from the PCP's attribution. A termination code will be listed on the report indicating the reason the recipient was terminated from the provider's attribution list. Below is the code legend that will be listed on the last sheet of the attribution report explaining the recipient's reason for termination.

Termination Reason Code	Description
1	RECIPIENT HAS BEEN ATTRIBUTED TO A NEW PROVIDER
2	RECIPIENT NO LONGER ASSIGNED TO AN ACHN NETWORK
3	RECIPIENT NOT MET MONTHS OF ELIGIBILITY REQUIRED
4	RECIPIENT HAD NO CLAIMS IN THE EVALUATION PERIOD
5	RECIPIENT HAS BEEN REKEYED. THIS ID IS NO LONGER ACTIVE

40.19.2 *Reconsideration of Attribution*

A PCP Group may request the attribution calculation for any Medicaid recipient who has received care from the group. If a PCP Group believes the Medicaid Agency has not properly attributed one or more Medicaid recipients to the PCP Group, it may request the Medicaid Agency reconsider its attribution calculation.

- A request for reconsideration must be submitted to the Medicaid Agency in writing and within seven business days of the quarterly attribution notification. The written request for reconsideration must contain:
    - the period of attribution
    - the name(s) of the Medicaid recipient(s) that the PCP Group believes was/were not properly attributed

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    - supporting information and/or documentation demonstrating that the Medicaid Agency either failed to or improperly considered information which had a material impact on the result of the attribution
- The PCP Group that has been attributed the Medicaid recipient(s) subject to the request for reconsideration shall be notified by the Medicaid Agency of the request and be permitted to submit information for Medicaid Agency consideration within three business days of the notice. If the PCP Group that has been attributed the Medicaid recipients subject to the request for reconsideration does not respond to Medicaid within the three-day time frame—Medicaid will continue the review without additional information from the attributed group.
- The Medicaid Agency will review all relevant information and complete any adjustments to the PCP Group's Medicaid recipient attribution within seven business days of receipt of the request for reconsideration.

  Reconsideration requests must be submitted to Patricia Toston at patricia.toston@medicaid.alabama.gov.

40.20 Quality Assurance Activities

Quality assurance activities and program monitoring will be the responsibility of the Managed Care Operations Division. Monitoring efforts will look at all facets of the program including measuring the PCP against established program goals, determining contract compliance, and focusing on program outcomes – all of which involve both administrative and performance measures.

Bonus Payments for the PCP Group will be available if the PCP Group:

- Enters into a Participation Agreement with an ACHN
- Actively participates with an ACHN
- Meets the criteria established by the Agency for quality
- Meets the criteria established by the Agency for cost effectiveness
- Achieves (or working towards) Patient Centered Medical Home (PCMH) Recognition.

Bonus Payments for Quality, Cost Effectiveness, and PCMH Recognition

This is a Bonus pool in the amount of $15 million annually to fund three (3) Bonus payments for eligible Participating PCP Groups. The Bonus Payment pool is allotted as follows:

- 50% for Quality
- 45% for Cost Effectiveness
- 5% for PCMH Recognition

The quarterly bonus payments will be made on the second or third checkwrite of the 1st month of the quarter (January, April, July, October).

The Alabama Medicaid Agency will set aside funds from the annual Alabama Coordinated Health Network (ACHN) bonus payment pool. The reserved funds will help assist with unforeseen situations that would cause the Agency to recoup and redistribute the bonus pool. The Agency will reserve a total of $400,000 from the annual $15 million bonus pool. This is equivalent to a reserve of $100,000 per quarter. If a primary care physician (PCP) group is inadvertently omitted from the bonus payment distribution, the Agency will use the reserve funds to pay the PCP

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group(s). In addition, if funds are recouped from a PCP group, the recouped amount will be added to the reserve funds. During the last quarter of the fiscal year, the Agency will distribute any remaining reserve funds to actively participating ACHN PCP groups.
For more information about the reserve funds, refer to the Changes to the Alabama Coordinated Health Network (ACHN) Bonus Payment Distribution ALERT on the Medicaid website.
Medicaid ALERTs: https://medicaid.alabama.gov/alerts.aspx

Quality Bonus Payments: PCP Groups will be eligible for a Quality Bonus Payment if the PCP Group meets the requirements described below:

- The Group must achieve at least half of the annual quality benchmarks determined by the Medicaid Agency
- Quality benchmarks are statewide, updated annually, and will be posted to the Agency's website at www.medicaid.alabama.gov (Click the ACHN tab/Provider).

PCP Quality Measures are listed below:

- Well-child visits for children, ages 3-6
- Adolescent well care visits
- Immunization status—Child
- Immunization status—Adolescent
- Antidepressant medication management
- HbA1c test for diabetic patients
- Follow-up after ER visit for alcohol or other drugs
- Chlamydia Screening in Women

Cost Effectiveness Bonus Payments:

PCP Groups will be eligible for a Cost Effectiveness bonus payment if the PCP group meets or exceeds the Cost Effectiveness criteria established by the Agency. Payments will be distributed to each PCP group that has met criteria. The Cost Effectiveness bonus calculation payment is described below:

- Compares a 12-month per member per month (PMPM) to a risk-adjusted expected PMPM based on the costs of similar PCP groups that treat Medicaid recipients
- Groups ranked by an efficiency score that is derived from actual PMPM versus the expected PMPM
- Bonus payment is paid for PCP groups with a cost effectiveness score of less than 1.0
- Recipients with total costs more than $250,000 will be removed from the PCP group's PMPM calculations and the ACHN statewide PMPM calculations
- Calculation occurs three months after the previous twelve (12) month's performance has been derived. For example, the quarterly payments made in January 2021 will be based on the actual Cost Effectiveness calculated for the period between October 1, 2019, and September 30, 2020, providing three months of claims payment completion. Likewise, the quarterly payments made in April 2021, will be based on the actual cost effectiveness calculated for the

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period between January 1, 2020 and December 31, 2020, to allow for three months of claims payment completion.

The Cost Effectiveness calculation includes a statewide PMPM calculation for the ACHN population. The Cost Effectiveness calculation excludes the most recent three (3) months of data, hospital access payments, entity case management costs, other bonus payments in the waiver, and drug rebates.

Recipients with total costs more than $250,000 will be removed from the PCP group's PMPM calculations and the ACHN statewide PMPM calculations.

A Cost Effectiveness Q&A document is available on the ACHN providers section of the Medicaid website, by visiting https://medicaid.alabama.gov/content/5.0_Managed_Care/5.1_ACHN/5.1.3_ACHN_Providers.aspx. The Cost Effectiveness Q&A document is a great resource for commonly asked questions and formulas used for cost effectiveness calculations.

Patient Centered Medical Home (PCMH) Recognition Bonus Payments:

The purpose of the PCMH Recognition Bonus payment is to incentivize providers to attain PCMH recognition ensuring Medicaid recipients are receiving care through a nationally recognized medical home model. Participating PCP groups can obtain PCMH recognition or certification through nationally recognized entities such as National Committee for Quality Assurance (NCQA), the Compliance Team, or the Joint Commission among others. The PCP group's PCMH Recognition certification of achievement and/or supporting documentation (proof) as adequate progress towards achievement must be in an active status on the last day in September of the (current) fiscal year in order to receive approval for the next fiscal year. For example, the quarterly payments made in October 2020, January 2021, April 2021, and July 2021 will be based on the PCP group's attestation of their achievement of recognition or certification as of the last business day in September 2020.

Details from NCQA can be found at: https://www.ncqa.org/programs/health-care-providers-practices/patient-centered-medical-home-pcmh/?utm_source=ncqa&utm_medium=homepage-link&utm_campaign=pcmh&utm_content=left .

Details from the Compliance Team can be found at: https://thecomplianceteam.org/our-accreditation-programs/patient-centered-medical-home-pcmh/

Details from the Joint Commission can be found at:https://www.jointcommission.org/certification/primary_care_medical_home_certification.aspx

All PCP groups will be required to attest to Medicaid no later than October 1st **annually**. All PCP groups will be required to submit the PCMH Attestation Form, regardless of which PCMH certifying agency the provider used to become PCMH recognized.

The PCMH Recognition bonus payment attestation and proof of (achievement or progress towards achievement) are due to Medicaid **annually**, **no later than the deadline date/time of October 1, by 5:00 P.M. (CST)**.

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PCMH Recognition (**adequate progress**) towards achievement is defined as follows:

a. National Committee for Quality Assurance (NCQA)- PCP groups must have completed at least 1 (one) check-in and met 1 or more Cores within the qualifying timeline for the upcoming fiscal year. Core met proof of supporting documentation must show continued progress until full PCMH Recognition has been obtained. Providers can send a screen print of the 'transforming' page in their dashboard from the NCQA website.

b. The Compliance Team- PCP groups must provide proof that progress has been made on their Quarterly PCMH Quality Reporting. Progress is defined as improvement in numbers as the months proceed. A blank PCMH Quality Reporting is unacceptable. The PCP group must have completed at least one (1) quarter with said entity and show continued progress towards PCMH Recognition accreditation.

c. The Joint Commission- PCP groups must provide proof that they have reached the 'Prepare for Survey' stage and/or beyond of the PCMH process. Additionally, at least 1 (one) of the tools within 'Prepare for Survey' must have been utilized or accessed to demonstrate progress.

PCMH achievement or progress toward PCMH achievement will be required from all PCP Groups that would like to receive a bonus payment for PCMH recognition beginning in the first quarter of FY 2021.

PCP Groups that received or making progress towards PCMH Recognition through NCQA, the Joint Commission, the Compliance Team or another certifying entity must submit an Attestation Form and proof of their PCMH Recognition certification to the Medicaid Agency.

For those PCP Groups who are working toward PCMH Recognition with a nationally recognized entity, progress toward completion of PCMH Recognition must be shown. The Agency will determine the appropriate level of progress to receive the 5% bonus payment. A screen print of this progress must be attached to the attestation form and can be obtained from the nationally recognized entity. The Agency will review the Attestation Form with the required attachments and will process based on established guidelines. If the Agency disapproves the submitted Attestation Form and attachments, a formal letter will be mailed to the PCP Group explaining the reason(s) for the disapproval.

Send the completed PCMH Attestation Form and its supporting documentation (proof) by:

Email: ACHN@medicaid.alabama.gov

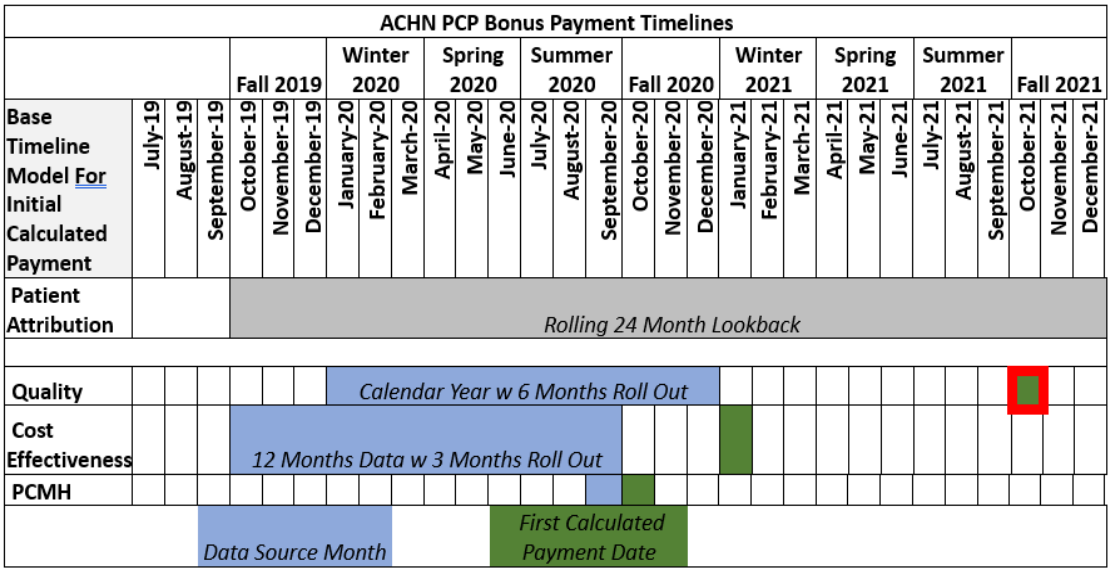
or

Fax: 334-353-3856

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Bonus Payment Timeline & Schedule

The timeline below represents the schedule the Agency will use to capture data and calculate bonus payments:



40.21 The Profile Report

The Profile Report (Profiler) is the scorecard for providers to easily determine why they receive or did not receive quality bonus payments. This report is based on claims information and one is produced for each PCP Group. The data in the report is collected from paid claims and is processed to produce a visual representation of how providers are performing within a peer group. More information on the Profile Report is posted on the Medicaid Agency's website.

40.22 Eligible Recipients

The Agency is responsible for recipient enrollment in Managed Care programs. ACHN is mandatory for most Medicaid recipients. Medicaid recipients that must participate in **ACHN** are those for whom eligibility has been determined as listed below. Eligibility categories include but are not limited to:

- Plan First recipients (women ages 19-55 and men 21 and older),
- Maternity Care recipients;
- Blind/Disabled children and adults;
- Aged and related populations;
- Children under age 19;
- Parents or other caretaker relatives (POCR);
- Foster children;
- Former Foster Care;
- Breast and Cervical Cancer; and
- American Indians (note: may opt-out at any time).

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Medicaid recipients listed in the below categories of Medicaid eligibility / in the following circumstances are **excluded from participation in ACHN:**

- Medicaid Dual Eligibles (covered by Medicare & Medicaid);
- Long-term institutional care;
- Home and Community-Based Services Waiver;
- Children in the custody of the Department of Youth Services;
- Inmates and people living in Institutions for Mental Diseases (IMDs);
- Aged, blind or disabled individuals receiving only optional state supplements;
- Individuals participating in the Program of All-Inclusive Care for the Elderly (PACE);
- Individuals utilizing hospice services;
- Individuals receiving Refugee Medical Assistance;
- Individuals with other commercial managed care insurance or participating in the Health Insurance Premium Payment (HIPP) program; and
- Individuals with limited or no Medicaid coverage (e.g., some non-citizens only eligible for emergency services, or individuals receiving short-term hospital presumptive eligibility).

40.23 Lock-in Recipients

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 and/or misuse of services. 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 letter of the pending restriction. They are asked to contact the Recipient Review Unit or the Clinical Services and Support Division 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 or the Clinical Services and Support Division to determine if they will agree to serve as primary care physician/designated pharmacy while the recipient is restricted.

40.23.1 *Referring Recipients with Lock-in Status*

Physicians who serve as a restricted recipient's lock-in provider should use the Alabama Medicaid Agency Referral Form (Form 362) when referring the restricted recipient to another physician. 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. This form can be obtained by accessing Medicaid’s website.

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NOTE:

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

40.24 Eligibility Verification

Always verify eligibility. It is the provider's responsibility to verify that a person is eligible for Medicaid at the time of service. There are three sources available for obtaining recipient information:

- The Provider Electronic Solution (PES) is a point of service device or PC based software system, which accesses recipient information.
- The Automated Voice Response System may be accessed by dialing 1 (800) 727-7848 using a touch-tone telephone. This is an automated telephone system available approximately 24 hours a day, 7 days a week unless down for maintenance.
- The Web User Guide provides instructions for performing recipient eligibility verification via the web portal. Instructions for accessing and login are also included in the guide. The Web Portal verification system will provide contact information for the recipient's attributed PCP. Providers can access the Web User Guide at the following link: https://www.medicaid.alabamaservices.org/ALPortal.

40.25 Emergency Services

Access to certified emergency services will not be restricted by the **ACHN** Program. Certified emergencies in outpatient emergency room settings do not require referral or prior authorization by the PCP. However, documentation should be maintained by the provider of service to support emergency certification.

40.26 Certified Emergency Services

Hospitals and physicians who provide "certified emergency" services in the Emergency Room (ER) are not required to have a referral from the PCP. Please note that follow-up care should not be certified as an emergency.

For certified emergencies, there must be an "E" indicator in the appropriate claim block. Refer to the Chapter Five of the Billing Manual for further instructions.

Providers should bill certified emergency services separately from those of non-certified emergency services.

The Agency stresses the importance of coordinating with the PCPs and ACHNs regarding the care of Medicaid recipients in order to preserve the continuity of care and the "medical home" concept.

40.27 Immunizations

Immunizations do not require PCP referral; however, the PCP must maintain documentation of immunizations received. Documentation must include the following: the date the immunization was given, the type of immunization, and who provided the immunization. PCPs are required to ensure that immunizations are up-to-date for children.

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Providers should be aware that the parent/guardian of children will be looking to the PCP for immunizations and/or documentation of immunizations, especially in the months prior to school starting. PCPs should be prepared to immunize these children or make arrangements to get appropriate information from the immunizing provider to meet the school rush. **ALL PCPs SHOULD MAKE EVERY EFFORT TO WORK WITH OTHER PROVIDERS IN THE COMMUNITY TO ENSURE THAT ALL CHILDREN ARE FULLY AND APPROPRIATELY IMMUNIZED**.

40.28 Program Enhancements

The following enhancements are designed to help the PCP achieve the overall program goal of establishing a medical home for our recipients that is accountable and cost-effective:

40.28.1 *Remote Patient Monitoring (RPM)*

Refer to Chapter 111 for more information on Remote Patient Monitoring (RPM).

40.29 Obtaining Educational Materials

Some materials that are available for download from the website include:

"Your Guide to Alabama Medicaid". This booklet describes the services covered, co-payments, the different types of eligibility, patient responsibilities, as well as other useful information.

"Alabama Medicaid Covered Services and Co-Payments" Handout (English or Spanish). Describes services covered by Medicaid and associated co-payments.

"EPSDT Brochure". This is a colorful pamphlet that encourages Well-Child checkups and outlines the periodicity schedule.

NOTE:

Educational materials are also available for use by providers and may be obtained using the online ordering form on the Agency's website at www.medicaid.alabama.gov. A catalog listing these materials is also on the website. Educational materials can be provided in other languages.

40.30 Medicaid Forms

The following forms can be found in Appendix E and/or on the Medicaid website www.medicaid.alabama.gov under Resources/Forms Library/ACHN/PCP Forms:

Form ID	Form Description
Form 172	EPSDT Child Health Medical Record
Form 284	To enroll children of Medicaid-eligible mothers (including SSI mothers) from birth to first birthday - with instructions
Form 391	PCP Override Request Form
ACHN Disenrollment Request Form	Group/PCP Disenrollment Requests
Immunization Documentation	Link to ADPH website regarding Pediatric, Adolescent and Adult Immunization Records

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40.31 PCP Billing Instructions

Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

40.32 Delivering Healthcare Professionals (DHCPs)

40.32.1 *Enrollment*

Gainwell enrolls providers who contract with Alabama Medicaid as a Delivering Healthcare Professional (DHCP). A copy of this contract will be required with the request to enroll as a DHCP.

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

Providers who contract with Alabama Medicaid as a DHCP are added to the Medicaid system with the National Provider Identifiers provided at the time application is made. Appropriate provider specialty codes are assigned to enable the provider to submit requests and receive reimbursements for Maternity Care related claims.

NOTE:
The 10-digit NPI is required when filing a claim.

ACHN DHCP Agreement: All DHCPs, including Maternal Fetal Medicine (MFM) and telemedicine providers, must sign one additional agreement beyond their Medicaid Enrollment. The DHCP must sign an agreement with an ACHN in order to receive reimbursement of maternity services and bonus payments. On a monthly basis, ACHNs will notify the Agency of all executed ACHN DHCP agreements. DHCPs and ACHNs must ensure that the Medicaid Group Billing ID, NPI, Medicaid ID, and name listed on the DHCP agreement is correct and consistent with what the Agency has on the provider's Medicaid file. The provider's file must also be in an active status with the Medicaid Agency. All information submitted must be based on the group level unless the DHCP is set up as an individual practice. If the information is not correct or consistent, the agreement will not be added to the provider's Medicaid file. In the absence of this agreement, DHCPs will not be eligible for reimbursement for maternity services and will not receive bonus payments for performing first trimester and post-partum visits. Contact the ACHN you intend to participate with to inquire about submission deadlines for the DHCP Agreement.

The enrollment effective date for the ACHN DHCP Agreement will the first day of the following month, if the agreement is received and contains no errors prior to the 15th of the month. For agreements received on or after the 15th of the month, the effective date of the enrollment will be the month following the next month.

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The DHCP group must work with the ACHN to ensure timely submission of the DCHP agreement. Contact the ACHN you intend to participate with to inquire about submission deadlines for the DHCP agreement.

To obtain the DHCP Group Agreement with the ACHN, email the ACHN Regional contact listed in section 40.1.

NOTE:

To receive reimbursement for maternity related services, all Maternal Fetal Medicine (MFM) and telemedicine providers must sign one additional agreement beyond their Medicaid Enrollment. The DHCP agreement must be signed with one of the ACHNs. (Refer to Chapter 112, Telemedicine Services, for general benefit information and limitations.)

40.33 Telemedicine Providers

Telemedicine providers who render maternity related services are required to sign a DHCP agreement with one of the ACHNs to receive reimbursement from Medicaid. Refer to Chapter 112 of the Provider Billing Manual to determine further requirements and procedure codes for telemedicine services.

Beginning July 8, 2020, Medicaid will allow physicians enrolled with the specialties OB/GYN (specialty type 328) and telemedicine (specialty type 931) to be reimbursed for maternity services with a referral from either an ACHN or the referring DHCP. The NPI of the ACHN, the DHCP, or the referring DHCP's group must be on the claim for reimbursement. Refer to section 40.43.2 (DHCP Selection Referral Number) for more detailed billing information.

Telemedicine providers who render maternity-related services are required to sign a Non-Delivering Telemedicine DHCP Participation agreement with at least one of the ACHNs in order to receive reimbursement from Medicaid. Refer to Chapter 112 of the Provider Billing Manual to determine further requirements and procedure codes allowed for telemedicine services.

NOTE:

Refer to Chapter 112, Telemedicine Services, for general benefit information and limitations.

40.34 ACHN Contact Information (for DHCPs)

Refer to Section 40.1: ACHN Overview for ACHN contact information for DHCPs.

40.35 DHCPs 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 Chapter 7, Understanding Your Rights and Responsibilities as a Provider, for general criteria on Medical Necessity/ Medically Necessary Care.

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40.36 Eligible Recipients

Refer to Section 40.22 for a listing of eligible recipients.

NOTE:

Medicaid SOBRA (Pregnant Women) recipients, who were once eligible for pregnancy-related services ONLY may receive full Medicaid benefits throughout pregnancy and post-partum, whether the services were pregnancy related or not. A Primary Care Physician (PCP) referral is NOT required to receive non-pregnancy related services.

Claims that are pregnancy related will require a pregnancy related diagnosis code or a postpartum diagnosis code. Co-pays may be applied for services that are non-pregnancy related. A recipient's age, health care requirements, and place of residence may further define his or her eligibility for Medicaid covered services. For this reason, it is very important that the providers verify recipient eligibility and ensure they understand all aspects of the eligibility response.

Eligibility responses have been changed to reflect the correct coverage for these women.

Refer to Chapter 4, Obtaining Prior Authorization (PA) for PA requirements.

Recipients are notified at the time of Medicaid application of the requirement to participate in the ACHN Program.

40.37 Recipient County Moves and Changes

Maternity recipients must receive a DHCP Selection Referral number from their assigned ACHN for maternity related services. In some instances, the maternity recipient may have a different county listed on their eligibility verification. In these situations, the maternity recipient must contact Medicaid to update their address and county. The recipient can update their address and county by calling the recipient call center, complete an update form (Form 295), contact their local caseworker, or use their My Medicaid online account. After the update has been requested, the address and county will update within 24 business hours. However, the ACHN assignment will not change until the following month (if completed on or before the 27th of the month). Until the ACHN assignment is updated, the DHCP must work with the ACHN that the recipient is currently assigned to for referrals.

40.38 Hospital Presumptive Eligibility

Hospital Presumptive Eligibility (HPE) is temporary Medicaid coverage for up to 60 days. Coverage begins the first day of the month and ends the last day of the following month if the person has not applied for regular Medicaid within the 60 days. The HPE application is approved by the HPE Determiner affiliated with a Qualified Hospital that has elected to participate. If a recipient is approved as pregnancy only, services are limited to ambulatory prenatal

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and pregnancy-related care only (inpatient expenses are not covered). To access the Patient HPE Application and the HPE Provider Agreement use the following link: http://medicaid.alabama.gov/content/9.0_Resources/9.4_Forms_Library/9.4.7_Hospital_Forms.aspx

40.39 Covered Services

All services provided by the DHCP will be billed fee for service.

40.39.1 *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

40.39.2 *Delivery*

Delivery includes vaginal delivery, with or without episiotomy, with or without forceps or cesarean section delivery. More than one fee **may not** be billed for a multiple birth delivery. Delivery includes, but is not limited to, professional services, such as physician's services and anesthesiology. Any non-routine newborn care must be billed under the baby's Medicaid number. Please refer to Chapter 28 for charges that are billable fee-for-service by physicians.

40.39.3 *Hospitalization*

Hospitalization includes delivery as well as any pregnancy-related hospitalizations that occur in the antepartum period or postpartum period. Hospitalization includes all charges that are normally submitted on the uniform billing claim form (UB-04), which includes but is not limited to the following:

- Labor
- Delivery or operating room
- Room and board including well baby nursery days
- Drugs, supplies, and lab/radiology services obtained during hospitalization

NOTE:
Physician sterilization charges may be billed fee-for-service.

All outpatient hospital services associated with a pregnancy related condition are to be billed as fee for service by the Provider of service utilizing the most

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appropriate CPT code. **A pregnancy diagnosis code, primary or secondary, must be used when billing maternity care services.**

40.39.4 *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 postpartum period. The postpartum exam should be accomplished 21 to 56 days after delivery.

40.39.5 *Care Coordination Services*

The ACHN care coordinator arranges a coordinated system of obstetrical care for pregnant women based on specific guidelines for care coordination services. The care coordination services provided by the ACHN for a maternity recipient are listed below:

- Eligibility assistance
- First face-to-face encounter
- Face-to-face or telephonic follow-up encounter (two encounters allowed if high risk)
- Inpatient face-to-face delivery encounter
- In home face-to-face postpartum encounter (for high-risk recipients)

40.39.6 *Assistant Surgeon Fees*

The assistant surgeon fees for cesarean (C-section) deliveries are to be billed fee for service.

40.39.7 *Anesthesia Services*

Anesthesia services include anesthesia services performed by an anesthesiologist or the delivering physician that are not medically contraindicated.

40.39.8 *Ultrasounds*

DHCPs must perform medically necessary ultrasounds and submit fee for service claims to Gainwell for payment. The details regarding ultrasounds are found in the Provider Billing Manual Chapter 28.

40.39.9 *Other Billable Services*

Services provided outside the scope of the global fee that may be billed separately are listed below:

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Separately Billable Service	***Description***
Drugs	Family planning or general drugs (for example, oral contraceptives or iron pills) prescribed by a provider with a written prescription to be filled later may be billed on a fee-for-service basis. In addition, women on Plan First have the option of obtaining oral contraceptives, the contraceptive ring, or the contraceptive patch, with a prescription from a private provider, at a Medicaid-enrolled community/outpatient pharmacy. Injections administered by the physician or outpatient facility can be billed on a fee-for-service basis (for example, Rhogam or Iron). Smoking cessation products for pregnant women will be covered after prior authorization through the Pharmacy Administrative Services contractor. Refer to Appendix Q Tobacco Cessation for additional information. The recipient must be enrolled and receiving counseling services through the Alabama Department of Public Health Quitline. Approval will be granted up to 3 months at a time.
Lab Services	All lab services except hemoglobin, hematocrit, and chemical urinalysis.
Radiology	All radiology services are outside of the global fee unless performed during an inpatient stay or for ultrasounds and non-stress tests. The professional component for radiology services is a component of the primary contractor global fee and should be billed separately to the primary contractor with the exception of teaching hospitals.
Dental	Effective **October 1, 2022**, Alabama Medicaid will reimburse for dental services rendered to pregnant adults who are ages 21 and older during pregnancy, and during postpartum in accordance with 42 CFR § 440.210(a)(3), when the services are rendered by Alabama Medicaid enrolled dental providers. Postpartum for dental services is 60 days post delivery or end of pregnancy. Services will not change for individuals under age 21.
Physician	Physician fees for family planning procedures (for example, sterilization), and genetic counseling. Claims for circumcision, standby and infant resuscitation may be billed under the mother's name and number on a fee-for-service basis.
Family Planning Services	Appropriate Family planning services with family planning procedure code or indicator. Eligible recipients will continue to have the option of receiving family planning services from the Alabama Department of Public Health or a Federally qualified Health Center. All family planning services must meet program guidelines and eligibility criteria.
Home Visit (99347-FP)	The home visit is a brief evaluation by a medical professional in the home of an established recipient and is for the purpose of providing contraceptive counseling (using the PT+3 teaching method) and administration/issuance of contraceptive supplies. The home visit is for postpartum women during the postpartum period and usually occurs within 7-14 days after delivery. A home visit is limited to one per postpartum period **and usually occurs within 7-14 days after delivery. A home visit is not a covered service for recipients with Plan First eligibility and can only be provided as a family planning service by Medicaid eligible family planning providers to eligible recipients**. 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 recipient: − understands how to use the method selected,

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	− 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 recipient must give her signed consent for this visit.
Extended Family Planning Counseling Visit (99212-FP)	The extended family planning counseling visit is a separate and distinct service consisting of a minimum of 10 face-to-face minutes of extended contraceptive counseling using the PT+3 teaching method. **The extended family planning counseling visit is for postpartum women during the postpartum period and is performed in conjunction with the 6-week postpartum visit in the office/clinic setting. An extended family planning counseling is limited to once during the post-partum period, and is not available for women who have undergone a sterilization procedure or Plan First eligible recipients on the Plan First Program.** 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**.** **An Extended Family Planning Counseling Visit is not covered for Plan First recipients and can only be provided as a family planning service by eligible family planning providers to eligible recipients.** The following services are required: • Contraceptive counseling and education • STD/HIV risk screening and counseling, and • Issuance of contraceptive supplies. **NOTE:** In the event of a premature delivery or miscarriage, the EDC, "Expected Date of Confinement", must be documented on the claim form in block 19 in order to be reimbursed for procedure code 99212-FP. All visits must be documented in the recipient's chart and reflective of the treatment and care provided.
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.
Mental Health	**S**creening, **B**rief Intervention, and **R**eferral to **T**reatment (SBIRT) are services designed to identify individuals who are at risk for development of substance use disorders, assist individuals in implementing strategies to reduce the potential for development of substance use disorders, and refer individuals who have identified needs for substance abuse treatment to specialized substance abuse treatment providers. Note: The intent of SBIRT is referral for Substance Abuse to include alcohol and drug abuse as smoking cessation is covered in the Maternity Care Program under Care Coordination Services. Screening: A full screen, as reimbursable through this benefit, is a structured process used to identify an individual whose current use of alcohol and/or other drugs creates a clearly defined risk for harm in some life dimension. A non-reimbursable pre-screening process must provide documentation of the need for a full screen. The pre-screening process may consist of, as few as, one to two brief questions incorporated into a general health questionnaire; a valid and reliable short screening tool; observations of attending medical personnel; interview and self-report; laboratory results; and/or concerns expressed by significant others.

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The full screen must be conducted utilizing an authorized, evidence-based screening tool with established reliability and validity in the identification of individuals who are at risk for developing substance use disorders. The tool must also provide enough information to establish an appropriate level of intervention in relation to each individual's identified risk factors. Authorized tools that may be used to conduct the full screen include the following:

- Alcohol, Smoking, and Substance Involvement Test (ASSIST)
- Drug Abuse Screening Test (DAST)
- Alcohol Use Disorders Identification Test (AUDIT)
- Car, Relax, Alone, Forget, Family or Friends, Trouble (CRAFFT) Questionnaire
- Problem Oriented Screening Instrument for Teenagers (POSIT)
- UNCOPE Substance Abuse Screening

Additional tools that conform to the criteria specified above may be utilized to provide the full screen. Prior to use, however, each tool not listed above must be reviewed and authorized for use by the Alabama Medicaid Agency.

The full screening process includes the provider's evaluation of the results and an explanation of these results to the individual who has been screened. The provider must clearly explain the level of risk associated with the identified alcohol and/or drug use pattern, and describe the corresponding implications within the context the individual's health and other life dimensions.

The provider's response to low risk substance use shall be provided during the screening process as according to the identified needs of the individual. This may include, but is not limited to, the dissemination of material that provides information on the risks associated with drinking and drug use, for example:

- Potential alcohol and drug interactions with medications the individual is taking.
- The potential for exacerbation of a health condition with alcohol and drug use.
- The potential impact of alcohol or drug use on pregnancy.

If the individual has a positive full screen, indicative of a moderate to high risk for a substance use disorder, the provider must be prepared to conduct or obtain brief intervention services during this same visit.

BRIEF INTERVENTION

A brief intervention is an organized encounter that includes, at a minimum, a provider and an individual who has been identified through a full screening process as being at moderate to high risk for development of a substance use disorder. Through the use of motivational strategies with demonstrated effectiveness, the goals of a brief intervention are to increase the individual's awareness and insight regarding current alcohol and/or drug use; to establish acceptance of a need for change; and to support the individual in development and implementation of a plan for change.

The brief intervention may consist of a single brief (15 minutes) session or multiple brief sessions dependent upon the unique needs of each individual. Referrals for specialized substance abuse treatment services are provided in conjunction with brief interventions. During any brief intervention, including the first session, the provider must be prepared to make a direct referral to a specialized substance abuse treatment provider for individuals who are at high risk for severe substance use and related consequences. Referrals must be initiated as soon a need for such is established.

SERVICE UNITS/LIMITS

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	Screening: H0049 **Service Unit:** Episode **Limit:** One per pregnancy Providers may bill for time that is spent face-to-face administering an authorized screening tool, discussing the screening results, and providing recommendations for further actions. Providers may not bill for the time during which an individual self-administers a screening tool. **Brief Intervention:** H0050 **Service Unit:** 15 minutes **Limit:** 1/day, 2/pregnancy Providers may bill for time that is spent face-to-face implementing strategies to assist individuals with moderate to high risks for development of substance use disorders in behavior modification that supports risk reduction. Allowable strategies include efforts made by the provider to assist the individual in accessing specialty substance abuse treatment services when there is an identified need for such. **Restrictions:** SBIRT services are not a covered benefit for: • Smoking and tobacco abuse. • Individuals who have been diagnosed with a substance use disorder. • Individuals who have had previous and/or are now receiving treatment for a substance use disorder. **Service Documentation:** Documentation of services provided shall incorporate the following: • The need for and method of identification of the need for SBIRT as established during a pre-screening process. • Identification of the screening tool used to conduct the full screening process. • The results of the full screening process. • Brief intervention goals unique to each individual. • Summary report of each brief intervention session conducted, including the implementation of established motivational strategies. • Referrals made and outcomes. • Follow-up services provided. **Approved Providers:** Coverage of Screening, Brief Intervention, and Referral for Treatment (SBIRT) for pregnant women is covered in conjunction with antepartum care provided by physicians, physician employed nurse practitioners, nurse midwives, physician-employed physician assistants and FQHCs. Prior to offering the services health care professionals must complete an online tutorial which can be accessed at http://www.mh.alabama.gov. The Mental Health and Substance Abuse Services Division of the Alabama Department of Mental Health will notify the Medicaid Maternity Care Program of health care professionals' successful completion of the tutorial. Procedure codes H0049 (screening for substance use) and H0050 (brief intervention and referral to treatment) will then be billable for the health care professional who has successfully completed the online tutorial. An ICD-10 code of Z331 must be billed by the provider on the claim form.
Referral to Specialists	DHCPs may provide referrals 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. A Board Certified Perinatologist is considered a specialty provider and may bill fee-for-service for high risk patients only. Refer to the Chapter 28, Physicians Chapter, for billing information.

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Non-Pregnancy Related Care	Services provided that are not pregnancy-related may be billed fee-for-service. A recipient's age, health care requirements, and place of residence may further define his or her eligibility for Medicaid covered services. For this reason, it is very important that the providers verify recipient eligibility and ensure they understand all aspects of the eligibility response. A provider may reference the fee schedules for a list of covered services on the following link: http://medicaid.alabama.gov/content/Gated/7.3G_Fee_Schedules.aspx.The fee schedules are not an all-inclusive list of procedure codes covered by the Agency. Reference Chapter 4, Obtaining Prior Authorization (PA) for PA requirements.
Tobacco Cessation Face-To-Face Counseling	The Alabama Medicaid Agency covers smoking cessation benefits for Medicaid-eligible pregnant women. Medicaid will reimburse for up to four face- to-face counseling sessions in a 12-month period. The reimbursement period will begin in the prenatal period and continue through the postpartum period. Documentation must support each counseling session. 28 Face-to-face counseling services must be provided: • By or under the supervision of a physician; • By other health care professionals who are legally authorized to furnish such services under State law and within their scope of practice and who is authorized to provide Medicaid coverable services other than tobacco cessation services. Refer to Appendix Q Tobacco Cessation for additional information.
Long Acting Reversible Contraception (LARC)	Effective for dates of service June 4, 2019, and thereafter Alabama Medicaid will reimburse the cost of the long acting reversible contraceptive to the facility when provided in the inpatient hospital setting immediately after a delivery or up to the time of the inpatient discharge for postpartum women, or in an outpatient setting immediately after discharge from the inpatient hospital for postpartum women. The insertion of the device/drug implant will be billable to Medicaid by both the physician and hospital for reimbursement. Refer to Chapter 19 Hospital for additional information. For questions regarding hospital billing contact the Medical Services Division. For questions regarding physician billing contact Jean Wackerle, Associate Director, Physicians Program, at (334) 242-2312 or via email Jean.Wackerle@medicaid.alabama.gov

40.40 Prior Authorization and Referral Requirements

DHCPs may provide referrals to specialists. Referrals to specialty providers for a pregnant recipient (i.e., Cardiology, Endocrinology, etc.) are paid fee-for-service.

Reference Chapter 4, Obtaining Prior Authorization (PA) for PA requirements.

40.40.1 *DHCP SELECTION REFERRAL REQUIREMENTS*

All maternity claims must have a DHCP selection referral number from the ACHN to receive payment from Medicaid. Although DHCPs will already have the ACHN NPI number, it is the responsibility of the DHCP to ensure a referral is in medical record and contact has been made with the ACHN. This ensures collaborative communication between the DHCP and the ACHN for quality health outcomes.

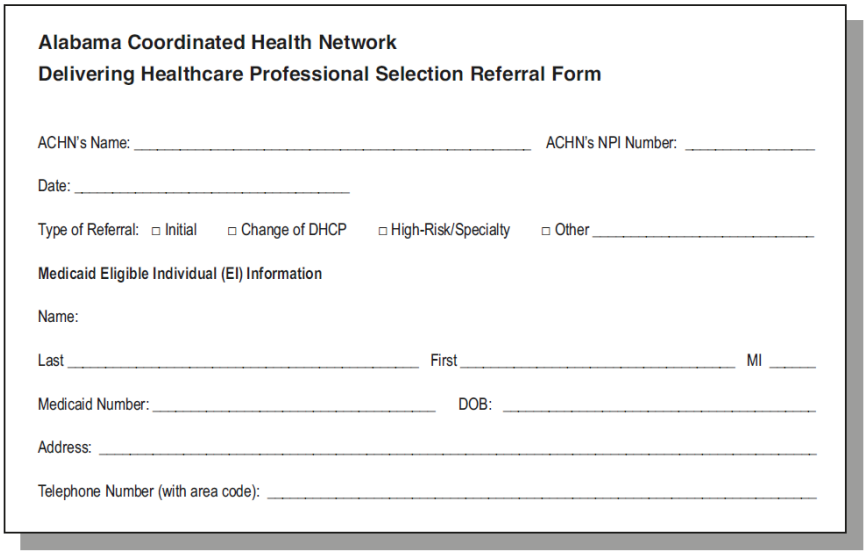
Exception: Medicaid Recipients that are not assigned to an ACHN on the date of service will not require a DHCP referral from the ACHN for reimbursement.

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NOTE:

In emergency circumstances, maternity claims submitted with an emergency indicator (Certified Emergency – Service Authorization Exception Code – 3) will not require a DHCP referral from an ACHN for reimbursement.

Sample ACHN DHCP Referral Form



Alabama Coordinated Health Network
Delivering Healthcare Professional Selection Referral Form

ACHN's Name: _____ ACHN's NPI Number: _____

Date: _____

Type of Referral: □ Initial □ Change of DHCP □ High-Risk/Specialty □ Other _____

Medicaid Eligible Individual (EI) Information

Name:

Last _____ First _____ MI _____

Medicaid Number: _____ DOB: _____

Address: _____

Telephone Number (with area code): _____

40.41 Spontaneous Abortions

Spontaneous abortions do not require a DHCP referral number from the ACHN. However, the DHCP should notify the ACHN when a pregnancy ends due to a spontaneous abortion.

40.42 Cost Sharing (Copayment)

Copayment does not apply to pregnancy-related services provided for pregnant women, but a relevant pregnancy or postpartum diagnosis code must be on the claim.

40.43 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When filing a claim on paper, a CMS-1500 claim form is required.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

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40.43.1 *Time Limit for Filing Claims*

Medicaid requires all claims from DHCPs to be filed within one year of the date of service. Refer to Chapter 5, Filing Claims, for more information regarding timely filing limits and exceptions.

40.43.2 *DHCP Selection Referral Number*

All maternity claims must have a DHCP selection referral number from the ACHN to receive payment from Medicaid. When filing an electronic claim using Medicaid's web portal, the DHCP Selection Referral Number should be entered into the "referring physician" field. If using a vendor/clearinghouse software, the provider will need to confirm with the vendor on where to enter the DHCP selection referral number.

NOTE:

If you use a billing software to submit claims and are not currently set up to insert the referring provider information, you may contact the EMC Helpdesk at 1-800-456-1242 for assistance in getting the software setup properly.

For paper claim submissions, the DHCP selection referral number should be entered as follows:

- **CMS-1500 Claims-** enter the name of the referring ACHN i block 17. Enter the secondary ID (Medicaid ID) in block 17A. The secondary ID may not always be necessary. Enter the ACHN's Referral Number (NPI) in block 17B.

- **UB-04 Claims-** Enter the ACHN's Referral Number (NPI) in block 78.

40.43.3 *Diagnosis Codes*

A pregnancy or postpartum diagnosis code, primary or secondary, must be used when billing maternity care services. At least two pregnancy diagnosis must be included on the claim. One of the diagnosis must be the weeks of gestation.

The *International Classification of Diseases - 10th Revision - Clinical Modification* (ICD-10-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, AMA Plaza 330 North Wabash Ave, Suite 39300 Chicago, IL 60611-5885, or 1-800-621-8335.

NOTE:

ICD-10 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.

40.43.4 *Procedure Codes, Modifiers, and Rates*

DHCPs are to bill all claims to Gainwell utilizing the appropriate CPT code. The following DHCP reimbursement table conveys ACHN delivery rates (effective 10/1/2019) for rural and urban delivery procedure codes:

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Code	*Modifier*	*Description*	*ACHN Rural*	*ACHN Urban*
59400	U9	Routine obstetric care including antepartum care, vaginal delivery **(delivery at 39 weeks of gestation or later)** (with or without episiotomy or forceps) and postpartum care	$2,090	$1,690
59400	UD	Routine obstetric care including antepartum care, vaginal delivery **(medically necessary delivery prior to 39 weeks of gestation)** (with or without episiotomy or forceps) and postpartum care	$2,090	$1,690
59400	UC	Routine obstetric care including antepartum care, vaginal delivery **(non-medically necessary prior to 39 weeks of gestation)** (with or without episiotomy or forceps) and postpartum care	$2,090	$1,690
59409	U9	Vaginal delivery only **(delivery at 39 weeks of gestation or later)** (with or without episiotomy and/or forceps)	$1,640	$1,340
59409	UD	Vaginal delivery only (**medically necessary delivery prior to 39 weeks of gestation**) (with or without episiotomy and/or forceps)	$1,640	$1,340
59409	UC	Vaginal delivery only (**non-medically necessary delivery prior to 39 weeks of gestation**) (with or without episiotomy and/or forceps)	$1,640	$1,340
59410	U9	Vaginal delivery **(delivery at 39 weeks of gestation or later)** and postpartum care only	$1,690	$1,390
59410	UD	Vaginal delivery **(medically necessary delivery prior to 39 weeks of gestation)** and postpartum care only	$1,690	$1,390
59410	UC	Vaginal delivery **(non-medically necessary prior to 39 weeks of gestation)** and postpartum care only	$1,690	$1,390
59510	U9	Routine obstetric care including antepartum care, cesarean delivery **(delivery at 39 weeks of gestation or later)** and postpartum care	$2,090	$1,690
59510	UD	Routine obstetric care including antepartum care, cesarean delivery **(medically necessary delivery prior to 39 weeks of gestation)** and postpartum care	$2,090	$1,690
59510	UC	Routine obstetric care including antepartum care, cesarean delivery **(non-medically necessary prior to 39 weeks of gestation)** and postpartum care	$2,090	$1,690
59514	U9	Cesarean delivery only **(medically necessary delivery prior to 39 weeks of gestation)**	$1,640	$1,340

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Code	*Modifier*	*Description*	*ACHN Rural*	*ACHN Urban*
59514	UD	Cesarean delivery only (**medically necessary delivery prior to 39 weeks of gestation**)	$1,640	$1,340
59514	UC	Cesarean delivery only **(non-medically necessary delivery prior to 39 weeks of gestation)**	$1,640	$1,340
59515	U9	Cesarean delivery **(delivery at 39 weeks of gestation or later)** and postpartum care only	$1,690	$1,390
59515	UD	Cesarean delivery **(medically necessary delivery prior to 39 weeks of gestation)** and postpartum care only	$1,690	$1,390
59515	UC	Cesarean delivery **(non-medically necessary delivery prior to 39 weeks of gestation)** and postpartum care only	$1,690	$1,390
59610	U9	Routine obstetric care including antepartum care, vaginal delivery **(delivery at 39 weeks of gestation or later)** (with or without episiotomy and/or forceps) and postpartum care, after previous cesarean delivery	$2,090	$1,690
59610	UD	Routine obstetric care including antepartum care, vaginal delivery (**medically necessary delivery prior to 39 weeks of gestation**) (with or without episiotomy and/or forceps) and postpartum care, after previous cesarean delivery	$2,090	$1,690
59610	UC	Routine obstetric care including antepartum care, vaginal delivery (**non-medically necessary delivery prior to 39 weeks of gestation**) (with or without episiotomy and/or forceps) and postpartum care, after previous cesarean delivery	$2,090	$1,690

Medicaid will reimburse maternity services to FQHCs and RHCs via PPS rates and Fee-For-Service rates. For more reimbursement information, refer to the FQHC and RHC chapters of the Provider Billing Manual.

NOTE:

Nurse Midwives will be reimbursed 80% of the physician rate.

Rural rates apply to the county location of the DHCP's offices. A map showing urban and rural counties for providers may be accessed on the Medicaid website at www.medicaid.alabama.gov, then select the ACHN tab, ACHN Providers, Medicaid's Designated Urban and Rural Map.

DHCP Initial Prenatal and Postpartum Bonus Payments:

Medicaid will pay $150.00 for each bonus payment and the following procedure codes must be submitted on a separate claim:

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- **H1000**-Initial Prenatal Visit. Actively participating DHCPs may bill procedure code **H1000** if the following criteria is met:
  - the Medicaid recipient has a confirmed pregnancy by a medical professional and/or lab test on or before the date of service and
  - the Medicaid recipient completes a gynecology/obstetrics medical visit within 90 days (12 weeks) of the last menstrual period.

- **G9357-**Postpartum Visit. Actively participating DHCPs may bill procedure code **G9357** if the following criteria is met:
  - the Medicaid recipient has delivered (including miscarriages/spontaneous abortions)
  - a paid delivery claim has been processed by the Alabama Medicaid Agency
  - the Medicaid recipient completes a visit with the DHCP between 21 and 56 days of the delivery

  - If a provider files procedure code G9357 between 21 and 56 days of delivery and receives a denial, the provider may submit an override request. The override request must be sent to:

Alabama Medicaid Agency
Managed Care Division
Attention: Linda White
501 Dexter Avenue
P.O. Box 5624
Montgomery, AL 36103-5624

Only one (1) Initial Prenatal and/or Postpartum DHCP bonus payment will be paid per Medicaid recipient per pregnancy. Duplicate DHCP bonus payments will not be paid for the same recipient during the same pregnancy.

Nurse Practitioners, Physician Assistants, and Nurse Midwives will receive 80% of the physician rate for these Bonus Payments. These Bonus Payments also apply to FQHCs and RHCs. If the Medicaid recipient is not assigned to an ACHN on the date of service, the DHCP will not be eligible for the Prenatal nor the Postpartum Bonus Payments. Refer to section 40.22 for a list of ACHN eligible and non-eligible recipients.

NOTE:
Non-citizens are not eligible for the Initial Prenatal (H1000) nor the Postpartum (G9357) bonus payments. Claims billed for non-citizens using the mentioned procedure codes will be denied.

Claims:

The (837) Professional and Institutional electronic claims and the paper claim have been modified to accept up to four Procedure Code Modifiers. Claims for maternity care services are limited to the following procedure codes and modifiers:

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NOTE:

Claims that are submitted for obstetric delivery procedure codes **59400, 59409, 59410, 59510, 59514, 59515, 59610, 59612, 59614, 59618, 59620, or 59622** will require one of the following modifiers:

U9-Delivery at 39 weeks of gestation or later

UD-Medically necessary delivery prior to 39 weeks of gestation

UC-Non-medically necessary delivery prior to 39 weeks of gestation

Claims for deliveries that are submitted without one of the required modifiers will be denied.

Appropriate Use of Modifiers

Please refer to this CMS link for more information regarding NCCI edits: https://www.medicaid.gov/medicaid/program-integrity/ncci/edit-files/index.html

Modifier 25 (Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service)

It may be necessary to indicate that on the day a procedure or service identified by CPT code was performed, the patient's condition required a significant, separately identifiable E&M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E&M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E&M service to be reported.

Reimbursement for Services

Global/delivery-only fees paid by Medicaid to the DHCP represent payment in full. **Recipients may not be billed for any services covered under this program.**

NOTE:

Providers are to bill the delivery only procedure codes for pregnant non-citizens.

High Risk Transfers/Reimbursement Methodology

Routine maternity care services provided to a recipient by a Delivering Healthcare Professional before and after the transfer of a recipient to a teaching physician as defined in Section 4,19-B of the State Plan or to a Medicaid enrolled Board Certified Perinatologist will be reimbursed **fee-for-service.** Perinatologists will not require a DHCP referral when billing for ultrasounds appending the 26 modifier.

NOTE:

Refer to Chapter 28, Physician, 28.2.11 Obstetrical and Related Services for general criteria regarding maternity services provided by teaching physicians.

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40.43.5 *Place of Service Codes*

The following place of service code applies when filing claims for maternity care services:

POS Code	*Description*
11	Office
21	Inpatient Hospital

40.44 Reporting Parity and Gravidity for DHCPs

The Medicaid Agency uses the American College of Obstetricians and Gynecologists (ACOG) definition for parity and gravidity. According to ACOG, gravidity is defined as the number of pregnancies, current and past, regardless of the pregnancy outcome. ACOG's definition of parity is the number of pregnancies reaching 20 weeks and 0 days of gestation or beyond, regardless of the number of fetuses or outcomes. In cases of multiple pregnancies, parity is only increased with birth of the last fetus.

Hence, parity cannot be greater than gravida. DHCPs should adhere to the ACOG's current definitions to report consistent information. For additional information on ACOG's definitions, visit the following link: https://www.acog.org/practice-management/health-it-and-clinical-informatics/revitalize-obstetrics-data-definitions

40.45 For More Information

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

Resource	Where to Find It
Becoming a Medicaid Provider	Chapter 2
Verifying Recipient Eligibility	Chapter 3
Obtaining Prior Authorization	Chapter 4
CMS-1500 Claim Filing Instructions	Chapter 5
Medical Necessity/Medically Necessary Care	Chapter 7
Physicians	Chapter 28
Long Acting Reversible Contraception (LARC)	Chapter 19
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N
Tobacco Cessation	Appendix Q

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40.46 Contact Information Summary

For general ACHN billing questions or to request an application package, call the Provider Assistance Center: 1 (800) 688-7989.

To disenroll from the program, the request may be faxed to Gainwell Provider Enrollment: (334) 215-4298 or mailed to Gainwell Provider Enrollment, PO Box 241685, Montgomery, AL 36124

To obtain recipient information on eligibility, benefit limits, or coverage, call the Provider Assistance Center: 1 (800) 688-7989

Automated Voice Response System: 1 (800) 727-7848

To address program and policy questions, for recipient language interpretation services or to report patients enrolled in ACHN who should not be enrolled, call the Recipient Call Center: 1(800) 362-1504

ACHN forms may be requested on Medicaid's website at www.medicaid.alabama.gov.

For written correspondence to the Agency: Alabama Medicaid Agency, 501 Dexter Avenue, P.O. Box 5624, Montgomery, AL 36103-5624.

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41 Nurse-Family Partnership (NFP)

Nurse-Family Partnership (NFP) is a nationally recognized, evidence-based program that provides prenatal, postpartum and infant home visiting services for the family unit until the child reaches age two. NFP nurse visiting services are available to eligible pregnant Medicaid recipients for intensive targeted case management rendered by specially trained nurses.

NFP nurse visiting services include care coordination, assessments and screenings, case management, and preventative health education and counseling. These nursing services are tailored to each woman's needs and delivered in-person or via telehealth in the home setting, or in an alternative community setting as indicated by recipient's need. The goals/objectives of the NFP program include:

- improved health outcomes for mother and child,
- reduced maternal and infant mortality rates, and
- an increase in healthy spacing between births to 24 months.

Referral by an Alabama Coordinated Health Network (ACHN) provider of an eligible Medicaid recipient to an Alabama Medicaid enrolled NFP entity is required. This referral is needed before the NFP entity submits for reimbursement to the Agency for services rendered to Alabama Medicaid recipients. Recipient participation in NFP is voluntary. Additionally, recipients can choose the Alabama Medicaid enrolled NFP provider in their region.

41.1 Provider Enrollment

Medicaid's fiscal agent enrolls providers and issues provider contracts to applicants who meet the licensure and/or certification requirements of the State of Alabama, the Code of Federal Regulations, the Alabama Medicaid Agency Administrative Code, and the Alabama Medicaid Provider Manual.

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

Federal requirements mandate providers re-validate periodically with the Alabama Medicaid program. Providers will receive a notification when it is time to re-validate. Failure to re-validate and provide appropriate documentation to complete the enrollment process will result in an end-date being placed on the provider file. A new enrollment application must be submitted once a provider enrollment file has been closed due to failure to timely re-validate.

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41.1.1 *National Provider Identifier, Type, and Specialty*

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

NOTE:
The 10-digit NPI is required when filing a claim

Nurse-Family Partnership providers are assigned a provider type of 21 (Targeted Case Management), and specialty code 923 (NFP).

41.1.2 *Enrollment Policy for NFP Providers*

Nurse-Family Partnership (NFP) provider entities may enroll with the Agency beginning April 1, 2022. An NFP provider entity must be certified by the National Service Organization (NSO) prior to enrolling with Alabama Medicaid. NFP certification requires, at a minimum, that each entity's appropriate personnel have NSO approved training in the prenatal, postpartum, and new parent topics.

Certified NFP entities must submit their NSO model fidelity letter when enrolling with Alabama Medicaid. Additionally, NFP provider entities will be required to pay an application fee in compliance with CMS requirements.

For information regarding becoming a certified NFP entity, please reference the information on the Agency's website on the NFP page.

41.1.3 *Provider Termination and/or Change of Ownership*

1. A participating Nurse-Family Partnership (NFP) provider has the right to withdraw from the Medicaid program after submitting written notice to Medicaid of its intent at least thirty (30) days in advance.
2. Medicaid may terminate the NFP provider's participation in the Medicaid program if the provider loses NSO certification for any reason, as well as in cases involving fraud or willful or grossly negligent non-compliance with all applicable program, State and federal guidelines.
3. Medicaid must be notified in writing within thirty (30) days of the date of an NFP entity's owner and/or name change. The existing contract will be terminated, and a new contract must be signed to continue participation in the Medicaid program.

41.2 Benefits and Limitations

41.2.1 *Benefits*

Nurse Family Partnership (NFP) services are available to Medicaid eligible persons who:

1. Are referred to a qualified, Agency enrolled, NFP entity/provider by the recipient's assigned ACHN.

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2. Recipients must meet the following NFP criteria for participation:

   - First time mother
   - High-risk as defined by the National Service Organization (NSO), and
   - Enrolls and receives her first home visit no later than the end of the 28th week of pregnancy, unless otherwise specified by NSO.

   NFP services include, but are not limited to:

   - Prenatal Services
     - Monitoring for high blood pressure or complications
     - Diet/nutrition education
     - Infant care education
     - Family stress guidance
     - Stress management
     - STD prevention education
     - Tobacco/alcohol education
     - Intimate partner violence screening/education
     - Anxiety and depression screening/referrals
     - Needs assessing/screening
     - Making referrals for care
     - Monitoring and follow up
   - Postpartum Services
     - Assessment of mom's health
     - Diet and nutrition education
     - Stress management
     - STD prevention education
     - Tobacco/alcohol education
     - Emotional/physical changes
     - Infant care and parenting
     - Partner relationship support
     - Breastfeeding support
     - Education for well-woman visits for preventive services
     - Anxiety and depression screening/referrals
     - Needs assessing/screening
     - Making referrals for care
   - Infant-Related Care
     - Infant health assessment, development and referrals
     - Child developmental screening at major developmental milestones from birth to age two (2).

41.2.2 *Limitations*

Medicaid will not separately reimburse for any direct care services, such as wound care, rendered by an NFP nurse in the course of their NFP case management visit.

41.3 Documentation Requirements

Nurse-Family Partnership (NFP) is a Targeted Case Management (TCM) service, and as such NFP providers must adhere to all core elements of TCM.

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For more information regarding these core elements, refer to TCM Chapter, Chapter 106, Section 106.2.1 of this Provider Billing Manual.

The NFP provider must maintain complete and accurate medical, mental health, case management, and fiscal records that fully disclose the extent of the services provided.

All documentation must be legible, signed and dated by the person (identified by name and discipline) who is responsible for ordering, providing, or evaluating the service furnished. Additionally, the author of each entry must either, personally or electronically sign his or her entry. A stamped signature is not acceptable.

In addition to all National Service Organization (NSO) mandated data elements and documentation requirements, NFP records must contain documentation of:

(a) name of recipient,

(b) the recipient Medicaid ID,

(c) the NSO Client ID,

(d) dates of services,

(e) name of NFP provider and person providing services,

(f) nature, start and end time, extent or units of services provided,

(g) place(s) of service,

(h) weeks of gestation or weeks postpartum at time of visit, and

(i) a written assessment of the client's progress.

The NFP provider's records must also contain the following information:

- Documented referral source
- A systematic, recipient-coordinated Plan of Care (POC).
- Verification that the recipient's Medicaid Eligibility was checked at admission and at least once a month, thereafter. NOTE: There are times when a recipient's eligibility status may change throughout the month. It is the provider's responsibility to ensure that a recipient has the applicable Alabama Medicaid coverage for the date(s) of service for which services will be provided. All providers must maintain a paper copy of the eligibility response in the patient's file. For more information, refer to the Provider Manual, Chapter 3: Verifying Recipient Eligibility.
- Family history
- Medical history
- Educational/vocational history
- Mental health treatment history, when applicable
- Legal history
- Substance abuse history

The NFP 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.

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41.4 Reimbursement

1. Nurse-Family Partnership (NFP) provider entities may submit a claim to Medicaid once each month for each family unit designated by the NSO Client ID. At least one qualifying visit must occur prior to the submission of the claim. However, it is expected that at least two visits per month with the recipient will occur and there must be documentation in the recipient's record for each visit performed. Additional visit dates must be listed on the claim as separate details. All visits beyond the first must be filed with an XE modifier appended to the corresponding NFP service (e.g., T2023 HD U1 XE). If at least two visits cannot be completed during the month, there must be documentation in the recipient's record to explain why. The dates of service must be listed on the claim. NOTE: Claims paid in error will be subject to recoupment.

NOTE:
Effective January 1, 2024, at least one of the minimal two monthly visits must be in-person or face-to-face to be eligible for reimbursement by Medicaid.

2. All NFP claims must have a referral from the recipient's assigned ACHN to receive payment from Medicaid. The Alabama Coordinated Health Network Nurse-Family Partnership (NFP) Referral Form must be completed in accordance to the instructions, ensuring the recipient's 13-digit Medicaid ID number is on the form. When filing an electronic claim using Medicaid's web portal, the ACHN NPI should be entered into the "referring physician" field. If using a vendor/clearinghouse software, the provider will need to confirm with the vendor on where to enter the ACHN NPI.

Added: The Alabama Coordinated…on the form.

3. All NFP claims must include the NSO Client ID to receive payment from Medicaid. When filing an electronic claim using Medicaid's web portal, the NSO Client ID should be entered in the "referral number" field. If using a vendor/clearinghouse software, the provider will need to confirm with the vendor on where to enter the NSO ID as the referral number.
4. NFP claims for prenatal services must include the Date of Last Menstrual Period (LMP) to receive payment from Medicaid. When filing an electronic claim using Medicaid's web portal, the LMP should be entered in the "Last Menstrual Period" field. If using a vendor/clearinghouse software, the provider will need to confirm with the vendor on where to enter the LMP (date qualifier code = 484).
5. NFP claims for post-partum services must include the Date of Delivery to receive payment from Medicaid. When filing an electronic claim using Medicaid's web portal, the Date of Delivery should be entered in the "Initial Treatment Date" field. If using a vendor/clearinghouse software, the provider will need to confirm with the vendor on where to enter the Date of Delivery/Initial Treatment Date (date qualifier code = 454).
6. The NFP provider agrees to accept payment in full as the amount paid for covered NFP services.

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41.4.1 *Completing the Claim Form*

To enhance the effectiveness and efficiency of Medicaid processing, providers are encouraged to bill Medicaid claims electronically.

NFP 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.

NFP providers must include the following information on the claim:

- The dates on which the NFP services were rendered,
- The recipient's ACHN NPI as referring provider,
- The NSO Client ID assigned to the family unit (referral number),
- The weeks of gestation or weeks postpartum at time of visit ,
- The ACHN referral number, and
- The Z71.9 (counseling, unspecified) diagnosis code

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

41.4.2 *Procedure Codes and Modifiers*

Medicaid uses the Healthcare Common Procedure Coding System (HCPCS). HCPCS is composed of the following:

- American Medical Association's Current Procedural Terminology (CPT)
- Nationally assigned codes developed for Medicare
- Locally assigned codes issued by Medicaid. Effective for dates of service on or after 01/01/2004, use national codes.

The CPT manual lists most procedure codes required by Medicaid. This manual may be obtained by contacting the Order Department, American Medical Association, 515 North State Street, Chicago, IL 60610-9986.

The following procedure code and applicable modifiers are required on each filed claim for NFP services:

Procedure Code	***First Modifier***	***Second Modifier***	***Date Required***
T2023 – Targeted Case Management (Monthly Billing)	HD – Pregnant and parenting women's program	U1 – Prenatal Case Management	LMP (date qualifier code = 484).
T2023 – Targeted Case Management (Monthly Billing)	HD – Pregnant and parenting women's program	U2 – Postpartum Period (delivery through 12 months postpartum)	Delivery Date (date qualifier code = 454).

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Procedure Code	*First Modifier*	*Second Modifier*	*Date Required*
T2023 – Targeted Case Management (Monthly Billing)	HD – Pregnant and parenting women's program	U3 – Postpartum Period (12 months through 2-years postpartum)	Delivery Date (date qualifier code = 454).

NOTE:

Postpartum services (U3) can be billed under the Mother or Child's Medicaid ID. Prenatal services (U1)and Postpartum (U2) MUST be billed under the mother's Medicaid ID.

NOTE:

Use of both a first and second modifier will be required for reimbursement.

41.4.3 *Diagnosis Codes*

Effective April 1, 2023, all Nurse-Family Partnership (NFP) claims submitted to Medicaid must include a diagnosis code of Z71.9 (counseling, unspecified) for reimbursement. Claims with dates of service prior to April 1, 2023 do not require the Z71.9 diagnosis code.

41.4.4 *Cost Sharing (Copayment)*

Copayment does not apply to services provided by NFP providers.

41.4.5 *Time Limit for Filing Claims*

Medicaid requires claims for NFP service 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.

41.5 For More Information

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

Resource	Where to Find it
Becoming a Medicaid Provider	Chapter 2
Verifying Recipient Eligibility	Chapter 3
CMS 1500 Claim Filing Instructions	Chapter 5
Targeted Case Management	Chapter 106
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N

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100

100 Children’s Specialty Clinics

Children's Specialty Clinic Services are specialty-oriented services provided by an interdisciplinary team to children who are eligible for EPSDT services and who experience developmental problems. Children's Specialty Clinic Services include preventive, diagnostic, therapeutic, rehabilitative, or palliative services provided in a clinic setting that is not part of a hospital but is operated to provide medical care on an outpatient basis to children with special health care needs.

Clinic services include the following outpatient services:

- Services furnished at the clinic by or under the direction of a physician or dentist
- Services furnished outside the clinic, by clinic personnel under the direction of a physician, to an eligible individual who does not reside in a permanent dwelling or does not have a fixed home or mailing address

  Clinics include:

Arthritis	Multiple Disabilities
Augmentative Communication	Neurology
Behavior Assessment (Sparks only)	Neuromotor
Biochemical Genetics (Sparks only)	Neurosurgery
Cerebral Palsy	Orthopedic
Child Development (Sparks only)	Pediatric Communication
Cleft Palate	Pediatric Evaluation
Cystic Fibrosis	Pediatric Orthopedic
Dentistry (Sparks only)	Pediatric Surgery
Eye	Psycho-education
Feeding (OT)	Scoliosis
Genetics	Seating, Positioning & Mobility
Hearing	Seizure
Hearing Aid	Speech Pathology
Hearing Assessment	Spina Bifida
Hemophilia	Teen Transition
Limb Deficiency	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.

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100.1 Enrollment

The Alabama Medicaid Agency fiscal agent enrolls children's specialty clinics and issues provider contracts to applicants who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Administrative Code,* and the *Alabama Medicaid Provider Manual.*

In order to meet federal enrollment criteria, all Children's Rehabilitation Services providers must have a NPI with ADRS/CRS identified as payee. Sparks Rehab Center shall submit claims for clinic services to Medicaid under the physician's clinic NPI or (if no physician is present) under the clinic NPI.

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

National Provider Identifier, Type, and Specialty

A provider who contracts with Alabama Medicaid as a clinic is added to the Medicaid system with the National Provider Identifiers provided at the time application is made. Appropriate provider specialty codes are assigned to enable the provider to submit requests and receive reimbursements for clinic-related claims. The 10-digit NPI is required when filing a claim.

Clinics are assigned a provider type of 57(Clinics). Valid specialties for clinics include the following:

- Children's Rehabilitation Service (015)
- EPSDT (560)
- Hemophilia (990)
- Orthodontia (273)
- Radiology Clinics (995)
- Sparks Rehab Center (850)
- Optometry (180)
- United Cerebral Palsy (UCP) (840)

Physicians and certified registered nurse practitioners affiliated with children's specialty clinics are enrolled with their own NPI, which links them to the clinic. The provider type for the physician and certified registered nurse practitioner is 57 (Clinics). The valid specialties are any of those specialties valid for physicians and certified registered nurse practitioner. Please refer to Chapter 28, Physician, for a listing of valid specialties.

All other personnel affiliated with the children's specialty clinic bill using the clinic's NPI and are not assigned individual NPIs.

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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
- Certified Registered Nurse Practitioners
- Nurses
- Social workers/service/care coordinators
- Physical therapists/Occupational therapists
- Audiologists
- Nutritionists
- Speech/language pathologists

All providers serving children must meet state and federal criteria for participation in the Medicaid program.

100.2 Benefits and Limitations

All Children's Specialty Clinic Services must be furnished by or under the direction of a physician directly affiliated with the clinic. "Under the direction of" means the physician must see the patient at least once, prescribe the type of care, and periodically (at least annually, unless the scope of services requires more frequent review) review the need for continued care.

Providers must develop a patient care plan that provides medical and rehabilitative services as well as coordination and support services to children with special health care needs.

Case management/service/care coordination is an integral part of ADRS/CRS clinic activities. Case managers/service/care 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/care coordinators must meet state licensure requirements at the appropriate educational level and receive training appropriate to the need of the target population.

Children's Specialty Clinic Teams

The clinic teams are usually comprised of physicians, certified registered nurse practitioners, registered nurses, social workers, therapists, audiologists, and rehabilitation assistants, clerical and/or support personnel. Clinic composition may vary depending on the type of clinic; however, clinic team protocol must be furnished to and approved by Medicaid. Clinic team protocol will be updated on an as-needed basis, but annually at a minimum. The team

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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 to include augmentative communication technology 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/Care coordination
- 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.

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. The cost report must be received by Alabama Medicaid Agency on or before February 28.

Non-governmental providers will be paid their usual and customary charge not to exceed the maximum allowable rate established by Medicaid.

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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.

Clinics must be attended either by a physician or a certified registered nurse practitioner. Some examples include:

- Arthritis
- Cerebral palsy
- Cleft palate
- Clubfoot
- Craniofacial
- Cystic fibrosis
- Eye
- Genetics
- Hearing
- Hemophilia
- Limb Deficiency
- Multi-specialty
- Neurology
- Neuromotor
- Neurosurgical
- Orthopedic
- Pediatric Evaluation
- Pediatric surgery
- Scoliosis
- Seizure
- Spina bifida
- Teen Transition
- Urology clinics

To be counted as a non-physician encounter, the health professional(s) must be qualified to perform the service, and although a physician is not present, the service must be provided under the direction of a physician. Examples of non-physician clinics include augmentative communication, feeding, hearing assessment, hearing aid orientation/maintenance, infant/toddler functional evaluation, speech, and seating, positioning & mobility.

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

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to an encounter, or subsequent to the clinic encounter, such as social services, case management, nursing, writing of prescriptions, clerical, therapy, and pre-certification evaluations are inclusive in the encounter and should not be billed separately.

For example, if a client comes to the limb deficiency clinic, the minimum staffing standards must be met in order for the contact to be counted as an encounter. In this case, the orthopedist, physical therapist, and social worker must be present. Their face-to-face contact with the client constitutes an encounter. Subsequent visits for purposes of physical therapy only by the therapist do not constitute an encounter since these costs are included in the encounter rate that is billed only when the minimum staffing standards for a clinic are met.

100.2.4 Maintenance of Records

The provider must make available to the Alabama Medicaid Agency at no charge all information regarding claims for services provided to eligible recipients. The provider will permit access to all records and facilities for the purpose of claims audit, program monitoring, and utilization review by duly authorized representatives of federal and state agencies. The provider maintains complete and accurate fiscal records that fully disclose the extent and cost of services.

The provider maintains documentation of Medicaid clients' signatures. These signatures may be entered on a sign-in log, service receipt, or any other record that can be used to indicate the clients' signatures and dates of service.

The provider maintains all records for a period of at least three years plus the current fiscal year. If audit, litigation, or other legal action by or on behalf of the state or federal government has begun but is not completed at the end of the three-year period, the provider retains the records until the legal action is resolved. The provider must keep records in a format that facilitates the establishment of a complete audit trail in the event the items are audited.

100.3 Prior Authorization and Referral Requirements

In general, clinic procedure codes generally do not require prior authorization; however, an exception to this requirement includes services for orthodontia. Refer to the Dental, Chapter 13 for guidelines.

For services outside of the encounter that require prior authorization, refer to Obtaining Prior Authorization, Chapter 4 for guidelines..

For services provided to recipients enrolled in the Alabama Coordinated Health Network (ACHN) Program, refer to Chapter 40, for guidelines.

100.4 Cost Sharing (Copayment)

Copayment does not apply to services provided by Children's Specialty Clinics.

100.5 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

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Children's specialty clinics that bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Online adjustment functions
- Enhanced access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When filing a claim on paper, a CMS-1500 claim form is required. Medicare-related claims must be filed using the Medical Medicaid/Medicare Related Claim Form.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

100.5.1 Time Limit for Filing Claims

Medicaid requires all claims for clinics to be filed within one year from the date of service. Refer to Section 5.1.5, Filing Limits and Approved Exceptions, for more information regarding timely filing limits and exceptions.

100.5.2 Diagnosis Codes

The *International Classification of Diseases - 10th Revision - Clinical Modification* (ICD-10-CM) manual lists required diagnosis codes.

ICD-9 codes should be used for claims submitted with dates of service prior to or equal to 09/30/2015.

ICD-10 codes should be used for claims submitted with dates of service on/after 10/01/2015.

ICD-9 or ICD-10 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

100.5.3 Procedure Codes and Modifiers

Medicaid uses the Healthcare Common Procedure Coding System (HCPCS). HCPCS is composed of the following:

- American Medical Association's Current Procedural Terminology (CPT)
- Nationally assigned codes developed for Medicare
- Locally assigned codes issued by Medicaid. Effective for dates of service on or after 01/01/2004, use national codes.

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The CPT manual lists most procedure codes required by Medicaid. The (837) Professional, Institutional and Dental electronic claims and the paper claim have been modified to accept up to four Procedure Code Modifiers.

The following procedure codes have been approved for billing by children's specialty clinics.

Clinic Services

Procedure Code	*Description*	*Who Can Bill*	*Sparks Clinic*
99203-HT	Neurology, also known as Pediatric Assessment, Pediatric Neurology, Neuromotor, Cerebral Palsy/Neuro Ortho, Cleft Palate, Craniofacial, Hemophilia, Limb Deficiency, Pediatric Orthopedic Specialty, Seizure, Speech, Pathology, and Spina Bifida/Multispecialty.	CRS	
99204-HT	Arthritis, Genetics, and Limb Deficiency.	CRS	
99212-HT	Arthritis, Cerebral Palsy/Neuro Ortho, Cleft Palate, Craniofacial, Craniofacial Orthodontia, Eye, Hearing, Hearing Aid, Hemophilia, Neuromotor, Neurosurgery, Orthopedic, Scoliosis, Spina Bifida/Multispecialty, Urology	CRS, Sparks	
99213-HT	Cerebral Palsy/Neuro Ortho, Cleft Palate, Craniofacial, Craniofacial Orthodontia, Hemophilia, Limb Deficiency, Neurology, also known as Pediatric Assessment, Pediatric Neurology; Neuromotor, Pediatric Orthopedic Specialty, Seizure, Speech Pathology, Spina Bifida/Multispecialty	CRS	
99214-HT	Cystic Fibrosis, Genetics, Arthritis	CRS, Sparks	Communicati on Clinic
99205-HT	Cystic Fibrosis, Pediatric Evaluation	CRS, Sparks	
99215-HT	Augmentative Communication, Cystic Fibrosis, Feeding, Hearing Aid, Hearing Assessment, Pediatric Evaluation, Seating, Teen Transition	CRS, Sparks	Behavioral Clinic, Biomedical Genetics
D9430	Dentistry Clinic	Sparks	

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CRS CLINIC TEAMS

SPECIALTY CLINIC	MEDICAL STAFF	PARA-MEDICAL STAFF	SOCIAL and ADMINISTRATIVE STAFF
ARTHRITIS CLINIC 99212-HT 99204-HT 99214-HT	*RHEUMATOLOGIST or IMMUNOLOGIST Ophthalmologist Orthopedist Or Registered Nurse Practitioner under the direction of a physician	*Registered Nurse *Physical Therapist Occupational Therapist Registered Dietitian	*Licensed Social Worker Administrative Support Assistant
AUGMENTATIVE COMMUNICATION/ TECHNOLOGY CLINIC Evaluation 99215-HT	Under the direction of a physician	*Speech-Language Pathologist *Physical Therapist *Occupational Therapist Rehabiltation Technology Specialist	*Licensed Social Worker Vocational Rehabilitation Counselor Administrative Support Assistant
CEREBRAL PALSY CLINIC 99212-HT Also known as NEURO-ORTHO CLINIC 99203-HT 99213-HT	*ORTHOPEDIST or PEDIATRIC NEUROLOGIST or NEUROLOGIST or PEDIATRICIAN or PHYSICAL MEDICINE Or Certified Registered Nurse Practitioner under the direction of a physician	*Registered Nurse *Physical Therapist *Registered Dietitian Occupational Therapist Speech-Language Pathologist	*Licensed Social Worker Administrative Support Assistant
CLEFT PALATE CLINIC 99212-HT 99203-HT 99213-HT	*PLASTIC SURGEON Or *ORAL SURGEON Or *ORAL MAXILLOFACIAL SURGEON Or *ORTHODONTIST or Dentist Pediatrician Geneticist Prosthodontist Otolaryngologist Or Certified Registered Nurse Practitioner under the direction of a physician	*Registered Nurse *Audiologist *Speech-Language Pathologist *Registered Dietitian Genetics Counselor/RN	*Licensed Social Worker Mental Health Counselor Administrative Support Assistant
CRANIOFACIAL CLINIC 99203-HT 99212-HT 99213-HT	*ORAL SURGEON Or *ORTHODONTIST Or *PLASTIC SURGEON Or Maxillofacial Surgeon NEUROSURGEON Dentist	*Registered Nurse *Speech-Language Pathologist *Registered Dietician Mental Health Counselor Audiologist Genetics Counselor/Nurse	*Licensed Social Worker Administrative Support Assistant
CRANIOFACIAL ORTHODONTIA CLINIC	*ORTHODONTIST DENTIST PROSTHODONTIST	*Registered Nurse *Speech-Language Pathologist	*Licensed Social Worker Administrative Support Assistant

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CRS CLINIC TEAMS

SPECIALTY CLINIC	MEDICAL STAFF	PARA-MEDICAL STAFF	SOCIAL and ADMINISTRATIVE STAFF
99213-HT 99203-HT 99212-HT		*Registered Dietician *Dental Assistant X-Ray Technician	
CYSTIC FIBROSIS CLINIC 99214-HT 99205-HT or 99215-HT	*PULMONOLOGIST Allergist/Immunologist Gastroenterologist Or Certified Registered Nurse Practitioner under the direction of a physician	*Registered Nurse *Registered Dietitian Respiratory Therapist Pharmacist Audiologist	*Licensed Social Worker Administrative Support Assistant
EYE CLINIC 99212-HT	*OPHTHALMOLOGIST or OPTOMETRIST Or Certified Registered Nurse Practitioner under the direction of a physician	*Registered Nurse Optician Ophthalmic Technician	*Licensed Social Worker Administrative Support Assistant
FEEDING CLINIC 99215-HT	Under the direction of a physician	*Registered Dietitian *Occupational Therapist *Speech-Language Pathologist *Registered Nurse	*Licensed Social Worker Administrative Support Assistant
GENETICS CLINIC 99204-HT or 99214-HT	*GENETICIST Or Certified Registered Nurse Practitioner under the direction of a physician	*Registered Nurse *Genetics Nurse/Counselor Registered Dietitian	*Licensed Social Worker Administrative Support Assistant
HEARING CLINIC 99212-HT	*OTOLARYNGOLOGIST Or Certified Registered Nurse Practitioner under the direction of a physician	*Audiologist *Registered Nurse Speech-language Pathologist Registered Dietitian	*Licensed Social Worker Administrative Support Assistant
HEARING AID CLINIC and Maintenance Evaluation 99215-HT 99212-HT	Under the direction of a physician	*Audiologist Registered Nurse Speech-Language Pathologist	Licensed Social Worker Administrative Support Assistant
HEARING ASSESSMENT CLINIC 99215-HT	Under the direction of a physician	*Audiologist Registered Nurse Speech-Language Pathologist	Licensed Social Worker Administrative Support Assistant
HEMOPHILIA CLINIC 99203-HT or 99212-HT 99213-HT	*HEMATOLOGIST Orthopedist Dentist Or Certified Registered Nurse Practitioner under the direction of a physician	* Registered Nurse *Physical Therapist Registered Dietitian	*Licensed Social Worker Administrative Support Assistant

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CRS CLINIC TEAMS

SPECIALTY CLINIC	MEDICAL STAFF	PARA-MEDICAL STAFF	SOCIAL and ADMINISTRATIVE STAFF
LIMB DEFICIENCY CLINIC 99213-HT or 99203-HT or 99204-HT	*PEDIATRIC ORTHOPEDIC SURGEON and/or PHYSICAL MEDICINE & REHABILITATION PHYSICIAN Or Certified Registered Nurse Practitioner under the direction of a physician	*Physical Therapist Prosthetist Occupational Therapist Registered Nurse	*Licensed Social Worker Administrative Support Assistant
NEUROLOGY CLINIC Also known as PEDIATRIC ASSESSMENT PEDIATRIC NEUROLOGY 99203-HT or 99213-HT	*NEUROLOGIST Or Certified Registered Nurse Practitioner under the direction of a physician	*Registered Nurse *Registered Dietitian Physical Therapist Occupational Therapist Speech-Language Pathologist	*Licensed Social Worker Administrative Support Assistant
NEUROMOTOR CLINIC 99212-HT or 99203 or 99213	*PHYSICAL MEDICINE Neurosurgeon Orthopedist Urologist Or Certified Registered Nurse Practitioner under the direction of a physician	*Registered Nurse *Physical Therapist *Registered Dietitian Occupational Therapist Speech-Language Pathologist DME Vendor	*Licensed Social Worker Recreational Therapist Administrative Support Assistant
NEUROSURGERY CLINIC 99212-HT	*NEUROSURGEON Or Certified Registered Nurse Practitioner under the direction of a physician	*Registered Nurse Physical Therapist (on call) Registered Dietitian	*Licensed Social Worker Administrative Support Assistant
ORTHOPEDIC CLINIC 99212-HT	*ORTHOPEDIST Or Certified Registered Nurse Practitioner under the direction of a physician	*Registered Nurse *Physical Therapist Registered Dietitian Occupational Therapist Speech-Language Pathologist Orthotist	*Licensed Social Worker Administrative Support Assistant
PEDIATRIC EVALUATION CLINIC 99205-HT or 99215-HT	*DEVELOPMENTAL PEDIATRICIAN Or NEONATOLOGIST Or PEDIATRICIAN Or Certified Registered Nurse Practitioner under the direction of a physician	*Registered Nurse *Physical Therapist Registered Dietitian Occupational Therapist Speech-Language Pathologist	*Licensed Social Worker Administrative Support Assistant
PEDIATRIC ORTHOPEDIC	*PEDIATRIC	*Registered Nurse *Physical Therapist	*Licensed Social Worker Administrative Support

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CRS CLINIC TEAMS

SPECIALTY CLINIC	MEDICAL STAFF	PARA-MEDICAL STAFF	SOCIAL and ADMINISTRATIVE STAFF
SPECIALTY CLINIC 99203-HT or 99213-HT	ORTHOPEDIST Or Certified Registered Nurse Practitioner under the direction of a physician	Registered Dietitian Occupational Therapist Speech-Language Pathologist DME Vendor Orthotist	Assistant
SCOLIOSIS CLINIC 99212-HT	*ORTHOPEDIST Or NEUROSURGEON Or Certified Registered Nurse Practitioner under the direction of a physician	*Registered Nurse *Physical Therapist Registered Dietitian Orthotist	*Licensed Social Worker Administrative Support Assistant
SEATING, POSITIONING & MOBILITY CLINIC 99215-HT	Under the direction of a physician	*Physical or Occupational Therapist	*DME SPECIALIST Licensed Social Worker Administrative Support Assistant
SEIZURE CLINIC 99203-HT or 99213-HT	*NEUROLOGIST Or Certified Registered Nurse Practitioner under the direction of a physician	*Registered Nurse *Registered Dietitian Pharmacist	*Licensed Social Worker Administrative Support Assistant
SPEECH PATHOLOGY CLINIC 99203-HT or 99213-HT	Under the direction of a physician	*Speech-Language Pathologist Audiologist	Licensed Social Worker Administrative Support Assistant
SPINA BIFIDA CLINIC 99212-HT 99203-HT 99213-HT Also known as: MULTI-SPECIALTY CLINIC	*Orthopedist or Neurosurgeon or Urologist or Rehab Medicine or Certified Registered Nurse Practitioner under the direction of a physician Adolescent Medicine	*Registered Nurse *Physical Therapist *Registered Dietician Occupational Therapist Orthotist DME Vendor	*Licensed Social Worker Administrative Support Assistant
TEEN TRANSITION CLINIC 99215-HT	Rehab Medicine or Adolescent Medicine Specialist or Pediatrician Or Certified Registered Nurse Practitioner under the direction of a physician	One or more of the following based on diagnosis/need: Nurse; Physical Therapist; Occupational Therapist; Audiologist; Nutritionist; Speech-Language Pathologist; Youth Consultant; Vocational Rehabilitation Counselor; Recreational Therapist	*Licensed Social Worker *Vocational Assessment Specialist and *one of the following: Rehabilitation Technology Specialist or Independent Living Specialist or Assistive Technology Specialist

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CRS CLINIC TEAMS

SPECIALTY CLINIC	MEDICAL STAFF	PARA-MEDICAL STAFF	SOCIAL and ADMINISTRATIVE STAFF
UROLOGY CLINIC 99212-HT	*Urologist Or Certified Registered Nurse Practitioner under the direction of a physician	*Registered Nurse Registered Dietitian	*Licensed Social Worker Administrative Support Assistant

*Denotes minimum staffing standards

NOTE:

Claims for Radiology codes 70010 – 79999 must be filed separately from claims for all other services.

Non-Clinic Services

Children's Specialty Clinics also provide, or arrange provision of, non-clinic services. The following procedure codes shall be utilized and will be reimbursed on a fee-for-service basis.

Procedure Code	*Who Can Bill*	*Description*
70010-79999	CRS	Radiology
J7188 J7189 J7190 J7191 J7192	CRS	Injection, Von Willebrand factor complex, per i.u. Factor ViiA, per 1mcg. Factor viii (antihemophilic factor, human), per i.u. Factor viii (antihemophilic factor, porcine), per i.u. Factor viii (antihemophilic factor, recombinant), per i.u.
J7197 J7198 J7199	CRS	Antithrombin iii (human), per i.u. Anti-inhibitor, per i.u. Hemophilia clotting factor, not otherwise classified
J7193 J7194 J7195	CRS	Factor ix (antihemophilic factor, purified, non-recombinant) Factor ix, complex, per i.u. Factor ix (antihemophilic factor, recombinant), per i.u.
D8080	CRS	Comprehensive Orthodontic Treatment of the Adolescent Dentition (requires prior authorization)
D8680	CRS	Orthodontic Retention (removal of appliances, construction, and placement of retainer(s)) (requires prior authorization)
D9310	CRS	Consultation
L3650	CRS	Shoulder orthosis (SO), figure of "8" design abduction restrainer
L3660	CRS	SO, figure of "8" design abduction restrainer, canvas and webbing
L3670	CRS	SO, acromio/clavicular (canvas and webbing type)
L3700	CRS	Elbow orthoses (EO), elastic with stays
L3710	CRS	EO, elastic with metal joints
L3720	CRS	EO, double upright with forearm/arm cuffs, free motion
L3730	CRS	EO, double upright with forearm/arm/cuffs, extension/flexion assist
L3740	CRS	EO, double upright with forearm/arm cuffs, adjustable position lock with active control
L3800	CRS	Wrist-hand-finger-orthoses (WHFO), short opponens, no attachments

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Procedure Code	*Who Can Bill*	*Description*
L3805	CRS	WHFO, long opponens, no attachment
L3810	CRS	WHFO, addition to short and long opponens, thumb abduction ("C") bar
L3815	CRS	WHFO, addition to short and long opponens, second M.P. abduction assist
L3820	CRS	WHFO, addition to short and long opponens, IP extension assist, with M.P. extension stop
L3825	CRS	WHFO, addition to short and long opponens, M.P. extension stop
L3830	CRS	WHFO, addition to short and long opponens, M.P. extension assist
L3835	CRS	WHFO, addition to short and long opponens, M.P. spring extension assist
L3840	CRS	WHFO, addition to short and long opponens, spring swivel thumb
L3845	CRS	WHFO, addition to short and long opponens, thumb IP extension assist with M.P. stop
L3850	CRS	WHFO, addition to short and long opponens, action wrist, with dorsiflexion assist
L3855	CRS	WHFO, addition to short and long opponens, adjustable M.P. flexion control
L3860	CRS	WHFO, addition to short and long opponens, adjustable M.P. flexion control and I.P.
L3900	CRS	WHFO, dynamic flexor hinge, reciprocal wrist extension/flexion, finger flexion/extension, wrist or finger driven
L3901	CRS	WHFO, dynamic flexor hinge, reciprocal wrist extension/flexion, finger flexion/extension, cable driven
L3906	CRS	WHO, wrist gauntlet, molded to patient model
L3907	CRS	WHFO, wrist gauntlet with thumb spica, molded to patient model
L3908	CRS	WHO, wrist extension control cock-up, non-molded
L3910	CRS	WHFO, Swanson design
L3912	CRS	HFO, flexion glove with elastic finger control
L3914	CRS	WHO, wrist extension cock-up
L3916	CRS	WHFO, wrist extension cock-up with outrigger
L3918	CRS	HFO, knuckle bender
L3920	CRS	HFO, knuckle bender, with outrigger
L3922	CRS	HFO, knuckle bender, two segments to flex joints
L3924	CRS	WHFO, Oppenheimer
L3926	CRS	WHFO, Thomas suspension
L3928	CRS	HFO, finger extension, with clock spring
L3930	CRS	WHFO, finger extension, with wrist support
L3932	CRS	FO, safety pin, spring wire
L3934	CRS	FO, safety pin, modified
L3936	CRS	WHFO, Palmer
L3938	CRS	WHFO, dorsal wrist
L3940	CRS	WHFO, dorsal wrist, with outrigger attachment
L3942	CRS	HFO, reverse knuckle bender
L3944	CRS	HFO, reverse knuckle bender, with outrigger
L3946	CRS	HFO, composite elastic
L3948	CRS	HFO, finger knuckle bender
L3950	CRS	WHFO, combination Oppenheimer, with knuckle bender and two attachments
L3952	CRS	WHFO, combination Oppenheimer, with reverse knuckler and

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Procedure Code	*Who Can Bill*	*Description*
		two attachments
L3954	CRS	HFO, spreading hand
L3960	CRS	Shoulder-elbow-wrist-hand orthosis (SEWHO), abduction positioning, airplane design
L3962	CRS	SEWHO, abduction positioning, erbs palsy design
L3964*	CRS	SEO, mobile arm support attached to wheelchair, balanced, adjustable – **Requires Prior Authorization**
L3965*	CRS	SEO-mobile arm support. Attached to wheelchair, balanced, adjustable rancho type – **Requires Prior Authorization**
L3966*	CRS	SEO, mobile arm support attached to wheel chair, balanced, reclining – **Requires Prior Authorization**
L3968*	CRS	SEO, mobile arm support attached to wheelchair, balanced, friction arm support (friction dampening to proximal and distal joints) – **Requires Prior Authorization**
L3969*	CRS	SEO, mobile arm support, monosuspension arm and hand support, overhead elbow forearm hand sling support, yoke type arm suspension support – **Requires Prior Authorization**
L3970*	CRS	SEO, addition to mobile arm support, elevating proximal arm – **Requires Prior Authorization**
L3972*	CRS	SEO, addition to mobile arm support, offset or lateral rocker arm with elastic balance control – **Requires Prior Authorization**
L3974*	CRS	SEO, addition to mobile arm support, supinator – **Requires Prior Authorization**
L3980	CRS	Upper extremity fracture orthosis, humeral
L3982	CRS	Upper extremity fracture orthosis, radius/ulnar
L3984	CRS	Upper extremity fracture orthosis, wrist
L3985	CRS	Upper extremity fracture orthosis, forearm, hand with wrist hinge
L3986	CRS	Upper extremity fracture orthosis, combination of humeral, radius/ulnar, wrist, (example-colles fracture)
L3995	CRS	Addition to upper extremity orthosis, sock, fracture or equal, each
L3999*	CRS	Upper limb orthosis, not otherwise specified – **Requires Prior Authorization**
L4000	CRS	Replace girdle for Milwaukee orthosis
L4010	CRS	Replace trilateral socket brim
L4020	CRS	Replace quadrilateral socket brim, molded to patient model
L4030	CRS	Replace quadrilateral socket brim, custom fitted
L4040	CRS	Replace molded thigh lacer
L4045	CRS	Replace non-molded thigh lacer
L4050	CRS	Replace molded calf lacer
L4055	CRS	Replace non-molded calf lacer
L4060	CRS	Replace high roll cuff
L4070	CRS	Replace proximal and distal upright for KAFO
L4080	CRS	Replace metal bands KAFO proximal thigh
L4090	CRS	Replace metal band KAFO-AFO, calf or distal thigh
L4110	CRS	Replace leather cuff, KAFO, calf or distal thigh
L4130	CRS	Replace pretibial shell
L4205	CRS	Repair pretibial shell
L4210	CRS	Repair of orthotic device, repair or replace minor parts
L8692-CG**	CRS	Auditory osseointegrated device, external sound processor, used without osseointegration, body worn, includes headband or other means of external attachment

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*Requires PA
**Effective January 1, 2014 and thereafter, procedure code L8692 must be filed with modifier CG

NOTE:
Refer to Chapter 37, Therapy (Occupational, Physical, and Speech) for the therapy codes.

100.5.4 Place of Service Codes

The place of service code 99 (Other Unlisted Facility) applies when filing claims for clinic services, except for dental and orthodontia services. For dental and orthodontia services, use place of service 11.

100.5.5 Required Attachments

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

- Claims With Third Party Denials

Refer to Section 5.8, Required Attachments, for more information on attachments.

100.6 Covered Services Eligible for Telemedicine

Refer to Chapter 112, Telemedicine Services, for general information and limitations.

100.7 For More Information

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

Resource	Where to Find It
CMS-1500 Claim Filing Instructions	Chapter 5
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

The Alabama Medicaid Agency fiscal agent enrolls county health departments and issues provider contracts to applicants who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Administrative Code*, and the *Alabama Medicaid Provider Manual.*

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

National Provider Identifier, Type, and Specialty

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

NOTE:
The 10-digit NPI is required when filing a claim.

County health departments are assigned a provider type of 13 (County Health). Valid specialties for county health departments that employ physicians include the following:

- Family Planning (083)
- Environmental Lead Assessment (980)
- EPSDT (560)
- Immunizations (900)
- Primary Care Clinic (720)
- Prenatal Clinic (181)
- Preventive Education (183)

County health departments that are enrolled to provide hospice services are assigned a provider type of 06 (Hospice). The valid specialty is Hospice (060).

County health departments that are enrolled to provide home health services are assigned a provider type of 05 (Home Health). The valid specialty is Home Health (050).

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NOTE:

Physicians affiliated with county health departments are assigned their own NPI, which links them to the health department. The provider type for the physician is 13 (County Health Department). The valid specialties are any of those specialties valid for physicians. Refer to Section 28.1, Enrollment, for a listing of valid physician specialties.

All other personnel affiliated with the county health department, such as physician assistants or nurse practitioners, bill using the health department's NPI.

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. Refer to Chapter 7, Understanding Your Rights and Responsibilities as a Provider, for general criteria on Medical Necessity/ Medically Necessary Care.

Consent of a Minor

Any minor who is 14 years of age or older; has graduated from high school; or is married, divorced, or pregnant may give effective consent to any legally authorized medical, dental, health, or mental health services for himself or herself. The consent of another person is not necessary.

101.2.1 EPSDT

County health departments providing EPSDT services should refer to Appendix A, EPSDT, for specifics regarding benefits and limitations.

EPSDT off-site screening providers must follow the protocols and procedures for EPSDT off-site services listed in the EPSDT appendix. Failure to comply may result in recoupment of the funds paid to the provider.

101.2.2 EPSDT Care Coordination

Effective March 1, 2004, the Alabama Medicaid Agency initiated an EPSDT care coordination service available for private and public providers. The goal for EPSDT Care Coordination Services is to provide children with opportunities to maximize their health and development by ensuring the availability and accessibility of comprehensive and continuous preventive health services throughout childhood.

The EPSDT Care Coordination services are available to any provider, at no cost, who wishes to utilize these services. The Agency, along with the Department of Public Health, has identified children at greatest risk and with the potential for effective intervention. These Medicaid eligible recipients will be targeted for outreach.

Scope of Services

The scope of services include and are designed to support physician's office personnel with identifying, contacting, coordinating, and providing follow up

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for children who identified with elevated blood lead levels, failed his/her initial hearing screening, or failed the required newborn screenings.

Reports

The following reports provided by the Alabama Medicaid Agency will be utilized by the Alabama Department of Public Health (ADPH) to assist with the following items.

- Monthly Eligibles Report – enables Care Coordinators the ability to track eligible recipients
- Monthly Selected Services Report – enables Care Coordinators to ascertain utilization of EPSDT services, immunizations, elevated blood lead levels, dental services, and high utilization of emergency room visits.

In addition, the Agency and ADPH has developed strategies to identify the children at greatest risk and with the potential for effective intervention utilizing diagnosis codes. Care Coordinators can track referrals, missed appointments, and follow up appointments utilizing the reports listed above.

The following information obtained from ADPH will be utilized as follows:

- Metabolic and Sickle Cell Screening – enables Care Coordinators the ability to track eligible recipients with abnormal results
- Newborn Hearing Screening - enables Care Coordinators the ability to track eligible recipients with abnormal results
- Immunizations - enables Care Coordinators the ability to track eligible recipients with inadequate or delayed immunizations

Measurement Criteria

- ADPH will provide a monthly Summary Report by county.
- EPSDT screenings, immunizations, dental screenings, follow up on elevated blood lead levels, referred visits, kept appointments will increase after the first two years of implementation.

Participation

Participation of qualified EPSDT Care Coordination services is available to the state of Alabama's designated Title V agency, Alabama Department of Public Health. Public Health's primary role is that of care coordinator. Public Health will provide clinical EPSDT services only where those services are not available through the private sector. Public Health will identify health problems. Procedure code G9008, type of service 1 with modifier "EP" (e.g., G9008-EP) will be utilized for billing purposes. Active physician involvement for treatment is vital. EPSDT Care Coordination services are available by contacting your local county health department. Please visit our website at www.medicaid.alabama.gov and select "Programs", then select "Medical Services". A list of EPSDT Care Coordinators by county and telephone numbers is available to support physician office personnel.

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101.2.3 Family Planning

County health departments providing family planning services should refer to Appendix C, Family Planning, for specific benefits, limitations, covered services and family planning diagnosis codes.

101.2.4 Prenatal

Prenatal services listed below are the services provided to a pregnant woman 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.

Medicaid provides prenatal services to persons who are eligible for Medicaid benefits and are deemed pregnant through laboratory tests or physical examination, without regard to marital status.

Prenatal services provided by county health departments must conform to the Program Guidelines for prenatal services under the Maternal and Child Health Services Block Grant Programs (Title V of the Social Security Act), Migrant Health Centers, or Community Health Centers.

Procedure	***Description***
99212-HD	Prenatal Clinic Visit – Includes diagnosis of pregnancy, comprehensive history, complete physical examination, preparation of medical record, risk assessment, diabetic and genetic screening, referral services, counseling services, collection of specimens for lab tests, hemoglobin or hematocrit and chemical urinalysis. Also includes reevaluation of the pregnancy during the prenatal period.
59430	Postpartum Clinic Visit – An in-depth evaluation of a patient in a stage of recovery from childbirth, requiring the development of or complete reevaluation of medical data, including history of labor and delivery, complications and/or pregnancy outcome, a complete physical examination, and the ordering of appropriate diagnostic tests and procedures. Patient education to include formal conference with the patient to review findings and contraceptive services.

101.2.5 Preventive Health

Refer to Chapter 30, Preventive Health Education, for specifics regarding benefits and limitations. Services are **limited** to the billing of the following two procedure codes:

Procedure Code	***Description***
S9445	Prenatal Education – Limited to pregnant female recipients. Limited to diagnosis codes V220 - V222 for ICD-9 and Z34.00, Z34.80, or Z33.1 for ICD-10.
99412	Adolescent Pregnancy Prevention Education – Limited to recipients ages 10-20. Limited to diagnosis code V2509 for ICD-9 and Z30.09 for ICD-10.

101.2.6 Environmental Lead Investigators

A qualified investigator must have graduated from a four-year college or university with a minimum of 30 semester hours or 45 quarter hours of continued coursework in biology, chemistry, environmental science, mathematics, physical science, or a minimum of at least five years of permanent employment in an environmental health field. Any person

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employed must have successfully completed the training program for environmentalists conducted by the Alabama Department of Public Health before being certified by the Alabama Department of Public Health.

Environmental Lead Investigations are billable as a unit of service. A unit of service is the investigation of the home or primary residence of an EPSDT-eligible child who has an elevated blood lead level. Testing of substances that must be sent off-site for analysis, or any non-medical activities such as removal or abatement of lead sources, or relocation efforts, are not billable as part of an Environmental Lead Investigation.

Please refer to Appendix A, EPSDT, for further information regarding lead levels and children.

101.2.7 Adult Immunizations

County health departments that provide immunizations to Medicaid-eligible recipients who are 19 years old and older must submit a claim for the appropriate HCPCS code. Vaccines are reimbursable on a fee-for-service basis. The administration fee is included in the price of the vaccine. Do not bill a separate procedure code for administration of the vaccine.

County health departments may bill only for the vaccine administration fee if the vaccine is provided at no cost to the provider from federal resources.

Refer to Appendix H, Alabama Medicaid Injectable Drug List, for procedure codes.

101.2.8 Home Health

County health departments providing home health care services should refer to Section 17.2, Benefits and Limitations, for specifics regarding home health benefits and limitations.

101.2.9 Hospice

County health departments providing hospice care services should refer to Section 18.2, Benefits and Limitations, for specifics regarding hospice benefits and limitations.

Refer to Section 18.5.3, Procedure Codes, Revenue Codes and Modifiers, for hospice procedure codes.

101.2.10 Physicians/Practitioners

Physicians and practitioners practicing within a county health department should refer to Section 28.2, Benefits and Limitations, for specifics regarding physician benefits and limitations.

Physicians have a NPI for each health department clinic/clinic type for which they provide services. Billable charges depend on the clinic, for example, Prenatal, EPSDT screening clinic, Family Planning, etc.

101.2.11 *Vaccines for Children (VFC)*

The Vaccines for Children (VFC) program offers free vaccines to qualified health care providers for children 18 years of age and under who are Medicaid eligible, American Indian or Alaskan Native, uninsured, or under-

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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.

When filing claims for recipients enrolled in the Alabama Coordinated Health Network (ACHN) Program, refer to Chapter 40, to determine whether your services require a referral from the Primary Care Physician (PCP).

101.4 Cost Sharing (Copayment)

The copayment amount for office visit* including crossovers is:

$3.90 for procedure codes reimbursed $50.01 and greater
$2.60 for procedure codes reimbursed between $25.01 and $50.00
$1.30 for procedure codes reimbursed between $10.01 and $25.00

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

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

If one of these CPT codes is applicable for your practice, then copay applies.

Copayment does not apply to services provided for pregnant women, nursing facility residents, recipients less than 18 years of age, emergencies, and family planning. Native American Indians that present an "active user letter" issued by Indian Health Services (IHS) will be exempt from the Medicaid required copayment.

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

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

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- Enhanced access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

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

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

101.5.1 Time Limit for Filing Claims

Medicaid requires all claims for county health departments to be filed within one year of the date of service. Refer to Section 5.1.5, Filing Limits and Approved Exceptions, for more information regarding timely filing limits and exceptions.

101.5.2 Diagnosis Codes

The *International Classification of Diseases - 10th Revision - Clinical Modification* (ICD-10-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, AMA Plaza 330 North Wabash Ave, Suite 39300 Chicago, IL 60611-5885, or 1-800-621-8335.

NOTE:

ICD-9 codes should be used for claims submitted with dates of service prior to or equal to 09/30/2015.

ICD-10 codes should be used for claims submitted with dates of service on/after 10/01/2015.

NOTE:

ICD-9 or ICD-10 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

101.5.3 Procedure Codes and Modifiers

Medicaid uses the Healthcare Common Procedure Coding System (HCPCS). HCPCS is composed of the following:

- American Medical Association's Current Procedural Terminology (CPT)
- Nationally assigned codes developed for Medicare
- Locally assigned codes issued by Medicaid. Effective for dates of service on or after 01/01/2004, use national codes.

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The CPT manual lists most procedure codes required by Medicaid. This manual may be obtained by contacting the Order Department, American Medical Association, 515 North State Street, Chicago, IL 60610-9986. The (837) Professional, Institutional, and Dental electronic claims and the paper claim have been modified to accept up to four Procedure Code Modifiers.

101.5.4 Place of Service Codes

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

POS Code	*Description*
11	Office
12	Home
34	Hospice
71	State or Local Public Health Clinic
81	Independent Laboratory

101.5.5 Required Attachments

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

- Claims With Third Party Denials

Refer to Section 5.8, Required Attachments, for more information on attachments.

101.6 For More Information

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

Resource	Where to Find It
CMS-1500 Claim Filing Instructions	Chapter 5
Sterilization/Hysterectomy/Abortion Requirements	Chapter 5
Medical Necessity/Medically Necessary Care	Chapter 7
EPSDT	Appendix A
Electronic Media Claims (EMC) Guidelines	Appendix B
Family Planning	Appendix C
Medicaid Standard Injectable Drug List	Appendix H
Outpatient Hospital/ASC Procedure List	Appendix I
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N
Alabama Coordinated Health Network (ACHN)	Chapter 40

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102

102 Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)

An Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID) is an institution that primarily provides the diagnosis, treatment or rehabilitation of individuals with Intellectual Disabilities or persons with related conditions. ICF-IIDs provides a protected residential setting, ongoing evaluations, planning, 24-hour supervision, and coordination and integration of health or rehabilitative services to help each individual function at their greatest ability.

The policy provisions for ICF-IID facilities can be found in the *Alabama Medicaid Agency Administrative Code,* Chapter 10.

102.1 Enrollment

Gainwell enrolls ICF-IID facilities and issues provider contracts to applicants who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code* and the *Alabama Medicaid Provider Manual.*

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

National Provider Identifier, Type, and Specialty

A provider who contracts with Alabama Medicaid as an ICF-IID provider is added to the Medicaid system with the National Provider Identifiers provided at the time application is made. The appropriate provider specialty code is assigned to enable the provider to submit requests and receive reimbursements for ICF-IID related claims.

NOTE:
The 10-digit NPI is required when filing a claim.

ICF-IID facilities are assigned a provider type of 3 (Intermediate Care Facility for Individuals with Intellectual Disabilities). The valid specialty for ICF-IID facilities is Intermediate Care Facility (030).

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Enrollment Policy for ICF-IID Facilities

To participate in the Alabama Medicaid Program, ICF-IID facilities must meet the following requirements:

- Possess certification through the Department of Public Health for Medicare Title XVIII and Medicaid XIX
- 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.

Change of Ownership (CHOW) and Closures

Medicaid will mirror Medicare's Change of Ownership (CHOW) policy. Refer to Chapter 19, Hospital for additional information on Change of Ownership.

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. Refer to Chapter 7, Understanding Your Rights and Responsibilities as a Provider, for general criteria on Medical Necessity/ Medically Necessary Care.

ICF-IID 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-IID facilities for therapeutic visits are limited to 14 days per calendar month.

Medicaid will track the use of therapeutic leave through the claims processing system.

An ICF-IID 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-IID 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 a retrospective review of ICF/IID facility records to determine appropriateness of admission on a monthly basis.

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102.2.3 Utilization Review

The Utilization Review function in the ICF-IID facilities is a facility-based review and will be performed by Medicaid or its designee every six months.

The facility staff must provide necessary administrative support to the review team during the review.

102.2.3 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.

102.2.4 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.

102.3 ICF-IID Applications

The medical determination for admission or continued care in an ICF-IID is made by the facility designated Qualified Intellectual Disabilities Professional (QIDP).

The facility must maintain the following documents for the retrospective review:

- A fully completed written application form 361 (Formerly XIX-LTC-18)
- The resident's physical history
- The resident's psychological history
- The resident's interim rehabilitation plan
- A social evaluation of the resident

Before the ICF-IID 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-IID 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

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eligible recipient or the recipient's sponsor cannot be billed when the ICF-IID fails to submit all forms in a timely manner.

102.4 Cost Sharing (Copayment)

Copayment does not apply to services provided by ICF-IID facilities.

102.5 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

Providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claims processing turnaround
- Ability to immediately correct claim errors
- Online adjustments capability
- Enhanced access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When an attachment is required, a hard copy UB-04 claim form must be submitted.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims for general claims filing information and instructions.

102.5.1 Time Limit for Filing Claims

Medicaid requires all claims for ICF-IID 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 - 10th Revision -Clinical Modification (ICD-10-CM)* manual lists required diagnosis codes. These manuals may be obtained by contacting the
American Medical Association, AMA Plaza 330 North Wabash Ave, Suite 39300 Chicago, IL 60611-5885, or 1-800-621-8335.

NOTE:

ICD-9 codes should be used for claims submitted with dates of service prior to or equal to 09/30/2015.

ICD-10 codes should be used for claims submitted with dates of service on/after 10/01/2015.

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NOTE:
ICD-9 or ICD-10 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

102.5.3 Covered Revenue Codes

Claims for ICF-IID facilities are limited to the following revenue codes:

Code	*Description*
101	All inclusive room & board
184	Leave of Absence/ICF/IID

102.5.4 Place of Service Codes

Place of service codes do not apply when filing the UB-04 claim form.

102.5.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to Claims with Third Party Denials.

Refer to Chapter 5, Section 5.8, 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
UB-04 Claim Filing Instructions	Chapter 5
Medical Necessity/Medically Necessary Care	Chapter 7
EPSDT	Appendix A
Electronic Media Claims (EMC) Guidelines	Appendix B
Outpatient Hospital/ASC Procedure List	Appendix I
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N

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103

103 Local Education Agencies (LEAs)

Federal law has made it possible for state education agencies to finance health-related education services through Medicaid and private insurance companies. Medicaid works with the State Department of Education, Special Education Services (SES), and the Local Education Agencies (LEAs) throughout the state to reimburse for these services.

Background Information

In 1975, the Individuals with Disabilities Education Act, formerly the Education for All Handicapped Children Act (P.L. 94-142) was signed into law, guaranteeing every child the right to a free, appropriate public education (FAPE) and related services in the least restrictive environment possible. Section 300.301 (a) (b) of the 34 Code of Federal Regulations states the following:

- Each State may use whatever state; local, federal, and private sources of support are available in the State to meet the requirements of this part. For example, when it is necessary to place a handicapped child in a residential facility, a State could use joint agreements between agencies involved for sharing the cost of that placement.
- Nothing in this part relieves an insurer or similar third party from an otherwise valid obligation to provide or to pay for services provided to a handicapped child.

In 1986, a General Accounting Office report recommended that Medicaid law be amended to allow Medicaid to pay for related services they typically would have covered if P.L. 94-142 were not in effect (GAO HRD 86-62BR). Congress acted on this recommendation through the Medicare Catastrophic Coverage Act (P.L. 100-360), which was signed into law on July 1, 1988.

A provision of P.L. 100-360 amended Section 1903 of the Social Security Act specifying that Medicaid was not restricted from covering services furnished to a child with disability simply because the services are included in the child's Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP). Congress further clarified that federal Medicaid matching funds are available for the cost of health services that are furnished to a child with disabilities, even though the services are included in the child's IEP or IFSP.

Regulations implementing the Individuals with Disabilities Education Act of 2004 require that school districts secure parental permission prior to billing Medicaid for services provided by the school districts. The regulation can be found at 34CFR 300.154(d).

In summary, Congress has established that while State education agencies are financially responsible for educational services, in the case of a Medicaid-eligible child, State Medicaid agencies remain responsible for the "related services" identified in a child's IEP if the services are covered under the State's Medicaid plan.

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In November 1989, the Omnibus Budget Reconciliation Act of 1989 (OBRA '89) was passed requiring Medicaid to cover all medically necessary services allowed under Section 1905(a) to "correct and ameliorate defects and physical and mental illnesses and conditions discovered by the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) screening, regardless of whether these services are included in the Medicaid State Plan." This act provides a mechanism for the local education agencies, through their professional staff, to bill Medicaid for health-related services that meet Medicaid's criteria for reimbursement.

Participation

Effective 04/01/12, the scope of services that can be reimbursed through the LEA was expanded. The LEA will need to have qualified subcontractors or employees in place to perform direct services. Refer to Section 103.5 for details on covered services. As explained in Section 103.5, the Cost Report is the mechanism that will be used to determine LEA interim payments and annual cost settlement amounts. However, LEAs may elect to continue to submit electronic claims through the MMIS vendor for additional documentation purposes. Reimbursement rates through the MMIS system have been set to zero to enable payments to be processed through the quarterly Cost Report and annual settlement process. If an LEA elects to submit claims through the MMIS vendor for documentation purposes, they will need to enroll as a Medicaid Provider. Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

The LEA must verify that no practitioner providing service has been terminated, suspended, or barred from the Medicaid or Medicare Program. The lists of terminated, suspended and barred practitioners are available on Medicaid's website at www.medicaid.alabama.gov.

LEA National Provider Identifier

A provider who contracts with Alabama Medicaid as an LEA is added to the Medicaid system with the National Provider Identifiers (NPI) provided at the time application is made. Appropriate provider specialty codes are assigned to enable the provider to submit requests and receive reimbursements for LEA-related claims.

NOTE:
The 10-digit NPI is required when filing a claim.

The qualifications for direct service providers are delineated in the scope of services. It is the responsibility of the LEA to ensure that direct service providers meet these qualifications. RNs, LPNs and School nurses must practice within the scope of the Standards of Nursing Practice as defined in Rule 610-X-6. Other practitioners must meet their own licensing requirements and practice within the scope of those licenses or credentials.

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103.1 Records and Samples

Providers of service are required to keep the following records and, upon request, furnish these records to authorized State representatives of the Alabama Medicaid Agency, the Department of Health and Human Services, the State Examiners of Public Accounts, the State Attorney General, the Comptroller General, the General Accounting Office, and the State Department of Education:

- A copy of the original and all updates of the Individualized Education Program (IEP), including parental signature. The IEP should be updated yearly.
- Description of specific professional services and activities provided with the date, the duration of services and activities rendered, and the name and title of the professional providing services and activities
- Dated updates/progress notes describing the student's progress, or lack thereof, signed or initialed by the professional providing services and activities
- The School's Official Attendance Record
- Discharge notes from services completed/treatment summary
- Description of the provider's activity during sampled time study moments

All records shall be completed promptly, filed, and retained for a minimum of five years from the date of services or until all audit questions, appeal hearings, investigations, or court cases are resolved, whichever is longer.

NOTE:

Failure to furnish records upon request may result in recoupment of funds paid.

103.1.1 Progress Notes

Medicaid highly recommends that therapists follow the SOAP method for recording appropriate documentation. The letters SOAP outline the four parts of documentation:

Subjective comment
Objective or goal
Assessment
Plan: Continue, Add, or Delete

An example of a progress note developed using the SOAP method would be:

Date	*Student progressing in all areas. Auditory discrimination tasks are improving (50 to 70%). Single word level production for new goals continues to be difficult. Continue present plan.* *Signature of Therapist*

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After the initial date of treatment, it is recommended that the therapist also SOAP all additional visits.

Date	*Showed marked improvement aud-dis (l) and blends; otherwise about the same. Encouraged to continue notebook. Continue present plan.* *Signature of Therapist*

NOTE:

Progress notes must be written after each service. Each progress note must be dated and signed or initialed. Electronic signatures on electronic medical records are acceptable.

103.1.2 Recipient Signature Requirement

Medicaid recognizes that the parents do not take their children to school each day; therefore, it would be impossible to obtain a parental signature for each date of service. To meet Medicaid's recipient signature requirement, the LEA must have the following:

- An IEP signed by the parent or responsible guardian that indicates the services the student will receive (for example, speech therapy three times a week for nine months)
- An attendance record that reflects the student was in attendance for the date of service

103.2 Prior Authorization and Referral Requirements

Services provided through an LEA do not require EPSDT, prior authorization or Alabama Coordinated Health Network (ACHN) referral.

103.3 Cost Sharing (Copayment)

Copayment does not apply to services provided through LEA providers.

103.4 New Cost Report Reimbursement Methodology

As approved by the Centers for Medicare and Medicaid Services (CMS) in August 2013 and effective as of April 1, 2012, the Alabama Medicaid Agency will begin calculating Medicaid reimbursement for direct medical services, through a Cost Report mechanism, for all Local Education Agencies. The Cost Report program is a cost-based, provider-specific methodology. LEAs complete a quarterly cost report with an annual Cost Settlement.

The reimbursement process for the direct medical services is comprised of the following parts:

- LEAs identify direct service providers on a quarterly basis (Participant List)
- LEAs participate in a Random Moment Time Study on a quarterly basis

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- LEAs complete a quarterly Cost Report
- Annual cost reconciliation and cost settlement is completed

103.5 FFS Interim Billing Process

The Cost Report is the mechanism that will be used to determine LEA interim payments and annual cost settlement amounts. However, LEAs may elect to continue to submit electronic claims through the MMIS vendor for additional documentation purposes. Reimbursement rates through the MMIS system have been set to zero to enable payments to be processed through the quarterly Cost Report and annual settlement process.

Refer to Appendix B, Electronic Media Claims Guidelines, for information.

103.5.1 Performing and Billing National Provider Identifiers

BILLING: In block 33 of the CMS-1500 claim form, enter the billing provider NPI and the billing provider's name.

PERFORMING: In block 24J of the CMS-1500 claim form, enter the School District's individual NPI.

The 10-digit NPI reflects services provided, per school district. A separate NPI will not be needed for each specialty that is providing services at each school district.

103.5.2 Place of Service

Claims should be filed with Place of Service (POS) Code 11 – office.

103.5.3 Time Limit for Filing Claims

Medicaid requires all claims for local education agencies to be filed within one year of the date of service. Refer to Section 5.1.5, Filing Limits and Approved Exceptions, for more information regarding timely filing limits and exceptions.

103.5.4 Diagnosis Codes

The *International Classification of Diseases - 10th Revision - Clinical Modification* (ICD-10-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, AMA Plaza 330 North Wabash Ave, Suite 39300 Chicago, IL 60611-5885, or 1-800-621-8335. The diagnosis code must come from the direct provider of service unless a diagnosis code is listed.

NOTE:

ICD-9 codes should be used for claims submitted with dates of service prior to or equal to 09/30/2015.

ICD-10 codes should be used for claims submitted with dates of service on/after 10/01/2015.

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NOTE:

ICD-9 or ICD-10 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

103.5.5 Required Claim Attachments

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

- Claims With Third Party Denials

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

103.6 Covered Services

Covered services are face-to-face health related services provided to a student, group of students, or parent/guardian on behalf of the student. Covered services are listed in the Alabama State Plan of Medical Assistance and are medically necessary for the development of the IEP or fully documented in the IEP. An IEP must be completed in order for services to be billed. Covered services are:

- Audiology Services
- Counseling Services
- Occupational Therapy
- Physical Therapy
- Personal Care Services
- Speech/Language Services
- Nursing Services
- Transportation Services

The CPT manual lists most required procedure codes. Certain CPT codes must be billed with the SE modifier as indicated. The services in this section may be covered by Medicaid when provided by an authorized provider according to an IEP. **Annual limitations are based on calendar year.**

The following paragraphs provide a detailed list of covered services, grouped by service.

103.6.1 Audiology Services

Service Description: Audiology services or documented in the IEP includes, but is not limited to evaluations, tests, tasks and interviews to identify hearing loss in a student whose auditory sensitivity and acuity are so deficient as to interfere with normal functioning.

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Professional Qualifications:

Audiology services must be provided by:

- A qualified audiologist who meets the requirements of, and in accordance with, 42 CFR §440.110(c), and other applicable state and federal law or regulation;

- A licensed/certified audiology assistant when the services are provided in a school setting and when these providers are acting under the supervision or direction of a qualified Audiologist in accordance with 42 CFR §440.110 and other applicable state or federal law.

Procedure Codes:

Procedure Code/ Modifier	*Description*	*Daily Limits*	*Annual Limits*
92551 SE	Screening test, pure tone, air only	1	12
92552 SE	Pure tone audiometry (threshold); air only	1	12
92553 SE	Pure tone audiometry (threshold); air and bone	1	12
92555 SE	Speech audiometry threshold	1	12
92556 SE	Speech audiometry threshold with speech recognition	1	12
92567 SE	Tympanometry (impedance testing)	1	12
92592 SE	Hearing aid check; monaural	1	12
92593 SE	Hearing aid check; binaural	1	12

103.6.2 Counseling Services

Counseling services are available to Medicaid-eligible recipients under the age of 21 years, who are eligible for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), and for whom the services are medically necessary. Medically necessary EPSDT services are health care, diagnostic services, treatment, and other measures described in section 1905(a) of Title XIX of the Social Security Act and, 42 CFR 440.130, that are necessary to correct or ameliorate any defects and physical and mental illnesses and conditions. These services are intended for the exclusive benefit of the Medicaid eligible child, documented in the IEP, and include but are not limited to:

1. Services may include testing and/or clinical observations as appropriate for chronological or developmental age. Such services are provided to:

    a. Assist the child and/or parents in understanding the nature of the child's disability;
    b. Assist the child and/or parents in understanding the special needs of the child;
    c. Assist the child and/or parents in understanding the child's development

2. Health and behavior interventions to identify the psychological, behavioral, emotional, cognitive, and social factors important to the prevention, treatment, or management of physical health problems. Qualified professionals may incorporate the following examples as a form of service. These examples are also recognized by the American Psychological Association as a therapeutic form of service. Qualified

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providers can determine the type of modalities that can be utilized based on the condition and treatment requirements of each individual and are not limited to these examples.

a. Cognitive Behavior Modification- This is a therapeutic approach that combines the cognitive emphasis on the role of thoughts and attitudes influencing motivations and response with the behavioral emphasis on changing performance through modification of reinforcement contingencies.
b. Rational-emotive therapy- A comprehensive system of personality change based on changing irrational beliefs that cause undesirable, highly charged emotional reactions such as severe anxiety.

c. Psychotherapy- Any of a group of therapies, used to treat psychological disorders, that focus on changing faulty behaviors, thoughts, perceptions, and emotions that may be associated with specific disorder. Examples include. individual interactive psychotherapy using play equipment, physical devices, language interpreter or other mechanisms of non-verbal communication, family therapy and sensory integrative therapy.

3. Assessing needs for specific counseling services.

Professional Qualifications:
Counseling services may be provided by:

- Licensed Psychologist;
- Licensed Psychological Associate;
- Licensed Certified Social Worker;
- Licensed Marriage and Family Therapist;
- Licensed Professional Counselor;
- Licensed Psychiatrist
- Registered nurse who has completed a master's degree in psychiatric nursing;
- Licensed School Psychologist when the services are provided in a school setting; or
- Licensed Specialist in School Psychology when the services are provided in a school setting.

Procedure Code/ Modifier	***Description***
96152 UB	Health and behavior intervention, each 15 minutes, face-to-face; individual
96153 UB	Intervention – group (per person)

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103.6.3 Occupational Therapy

Service Description: Occupational Therapy services, for the development of the students IEP or documented in the IEP include, but are not limited to:

1. Evaluation of problems which interfere with the student's functional performance
2. Implementation of a therapy program or purposeful activities which are rehabilitative, active or restorative as prescribed by a licensed physician,

   These activities are designed to:

   a) improve, develop or restore functions impaired or lost through illness, injury or deprivation,

   b) improve ability to perform tasks for independent functioning when functioning is impaired or lost,

   c) prevent, through early intervention, initial or further impairment or loss of function,

   d) correct or compensate for a medical problem interfering with age appropriate functional performance.

Professional Qualifications:

- Must be licensed by the Alabama State Board of Occupational Therapy and meet the requirements of, and in accordance with, 42 CFR §440.110(b);

- Occupational therapy assistants may assist in the practice of occupational therapy only under the supervision of an OT. Occupational therapy assistants must have an Associate of Arts degree and must be licensed by the Alabama State Board of Occupational Therapy. Supervision of certified OT assistants must include one-to-one on-site supervision at least every sixth (6th) visit. Each supervisory visit must be documented and signed by the OT making the visit.

All services must be performed within the scope of services as defined by the licensing board.

Procedure Codes:

Medicaid **does not** cover group occupational therapy. Covered occupational therapy services do not include recreational and leisure activities such as movies, bowling, or skating. Use the following procedure codes for services prescribed by a physician and provided by a qualified occupational therapist:

Procedure Code/ Modifier	*Description*	*Daily Limits*	*Annual Limit*
97003 SE	Occupational therapy evaluation	1	1
97004 SE	Occupational therapy re-evaluation	1	1
97110 SE	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility*	4	96

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*If additional services are needed, provider of service must use modifier 22. Medicaid monitors the use of this modifier. Documentation in medical record must support use of modifier 22 by reflecting continued improvement of condition for which therapy is ordered.

103.6.4 Physical Therapy

Service Description: Physical Therapy services, necessary for the development of the student's IEP or documented in the IEP include, but are not limited to:

1. Evaluations and diagnostic services
2. Therapy services which are rehabilitative, active, restorative. These services are designed to correct or compensate for a medical problem and are directed toward the prevention or minimization of a disability, and may include:
    a. developing, improving or restoring motor function
    b. controlling postural deviations
    c. providing gait training and using assistive devices for physical mobility and dexterity
    d. maintaining maximal performance within a student's capabilities through the use of therapeutic exercises and procedures.

Professional Qualifications: Must be licensed by the Alabama Board of Physical Therapy. Physical therapy assistants may provide services only under the supervision of a qualified physical therapist. PT assistants must be licensed by the Alabama Board of Physical Therapy. Supervision of licensed PT assistants must include one-to-one on-site supervision at least every sixth (6^{th}) visit. Each supervisory visit must be documented and signed by the PT.

All services must be performed within the scope of services as defined by the licensing board.

Procedure Codes:

Use the following procedure codes for services prescribed by a physician and provided by a qualified physical therapist. Physical therapy is not covered for groups. Physical therapy services may not be span billed.

Procedure Code/Modifier	***Description***	***Daily Limits***	***Annual Limit***
97001 SE	Physical therapy evaluation	1	1
97002 SE	Physical therapy re-evaluation	1	1
97110 SE	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility*	4	96

*If additional services are needed, provider of service must use modifier 22. Medicaid monitors the use of this modifier. Documentation in medical record must support use of modifier 22 by reflecting continued improvement of condition for which therapy is ordered.

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103.6.5 Personal Care Services

Service Description: EPSDT services are health care, diagnostic services, treatments, and other measures necessary to correct or ameliorate defects and physical and mental illnesses and conditions.

Personal care services are support services furnished to a client who has physical, cognitive, or behavioral limitations related to the client's disability or chronic health condition that limit the client's ability to accomplish activities of daily living ADLs), instrumental activities of daily living (IADLs), or health-related functions. Personal care services provided to students on specialized transportation vehicles are covered under this benefit. Services must be authorized by a physician in accordance with a plan of treatment or (at the State's option) in accordance with a service plan approved by the State. Personal care services may be provided in an individual or group setting, and must be documented in the IEP/IFSP.

Individuals providing personal care services must be a qualified provider in accordance with 42 CFR *5* 440.167, who is 18 years or older, has a high school diploma or GED, and has been trained to provide the personal care-services required by the client. Training is defined as observing a trained employee on a minimum of three patients and verbalization of understanding the personal care service. When competence cannot be demonstrated through education and experience, individuals must perform the personal assistance tasks under supervision.

Personal care services will not be reimbursed when delivered by someone who is a legally responsible relative or guardian. Service providers include: individual attendants, attendants employed by agencies that meet the state requirements. Special education teachers and special education teacher's aides can qualify as personal care worker. They must demonstrate the services they are providing meet the personal care service definition that the personal care service is documented in the IEP, and their services are to assist the student is accomplishing ADL and IADL and not activities that support education or instruction.

Procedure Code/ Modifier	***Description***	***Unit of Service***
T1019 U5	Individual, school	15 minutes
T1019 U5 & UD	Group, school	15 minutes
T1019 U6	Individual, bus	Per one-way trip
T1019 U6 & UD	Group, bus	Per one-way trip

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103.6.6 Speech/Language Services

Service Description: Speech/language therapy services necessary for the development of the student's IEP or documented in the student's IEP include, but are not limited to:

1. Diagnostic services
2. Screening and assessment
3. Preventive services
4. Corrective services

Speech therapy services may be provided in an individual, group or family setting. The number of participants in the group should be limited to assure effective delivery of service.

Professional Qualifications:

Speech and language services must be provided by:

- A qualified speech/language pathologist (SLP) who meets the requirements of, and in accordance with, 42 CFR §440.110(c), and other applicable state and federal law or regulation;
- American Speech-Language-Hearing Association (ASHA) certified SLP with Alabama license and ASHA-equivalent SLP (i.e., SLP with master's degree and Alabama license) when the services are provided in a school setting; or
- A provider with a state education agency certification in speech language pathology or a licensed SLP intern when the services are provided in a school setting and when these providers are acting under the supervision or direction of a qualified SLP in accordance with 42 CFR §440.110 and other applicable state or federal law

All services must be performed within the scope of services as defined by the licensing board.

Procedure Codes:

Use the following procedure codes for services provided by a qualified speech pathologist for individuals with speech disorders. Speech therapy services may not be span-billed.

Procedure Code/ Modifier	***Description***	***Daily Limits***	***Annual Limits***
92506 SE	Evaluation of speech, language, voice, communication, and/or auditory processing	1	4
92507 SE	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual	1	300
92508 SE	Treatment of speech, language, voice, communication, and/or auditory processing disorder; group 2 or more individuals	1	300

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103.6.7 Nursing Services

Service Description: Nursing services outlined in this section of the state plan are available to Medicaid eligible recipients under the age of 21 years, who are eligible for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services and for whom the service is medically necessary, and these services must be documented in the IEP/IFSP.

Nursing services are defined as the promotion of health, prevention of illness, and the care of ill, disabled and dying people through the provision of services essential to the restoration of health.

Professional Qualifications:

The Registered Nurse and Licensed Practical Nurse shall be licensed by the State of Alabama to provide the services and practice within the scope as outlined by the Alabama Board of Nursing. Nursing services must be provided by a qualified nurse who meets qualification requirements of, and in accordance with, 42 CFR 440.60 and, on a restorative basis, under 42 CFR 440.130(d), including services delegated in accordance with the Alabama Board of Nursing to individuals who have received appropriate training from an RN , including nursing services delivered by advanced practice nurses (APNs) including nurse practitioners (NPs) and clinical nurse specialists (CNSs), registered nurses (RNs), licensed practical nurses (LPNs) and licensed vocational nurses (LVNs).

Procedure Code/ Modifier	***Description***	***Unit of Service***
T1002 TD	RN services up to 15 minutes/Individual	15 minutes
T1002 TD & UD	RN services up to 15 minutes /Group	15 minutes
T1502 TD	Medication admin visit/RN	Medication administration, per visit
T1002 U7	RN services up to 15 minutes /Delegation, Individual	15 minutes
T1002 U7 & UD	RN services up to 15 minutes /Delegation, Group	15 minutes
T1502 U7	Medication admin visit	Delegation, medication administration, per visit
T1003 TE	LPN/LVN services up to 15min/individual	15 minutes
T1003 TE & UD	LPN/LVN services up to 15min /Group	15 minutes
T1502 TE	Medication admin visit/LPN or LVN	Medication, administration per visit

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103.6.8 Transportation

Service Description: Specialized transportation services include transportation to receive Medicaid approved school health services. This service is limited to transportation of covered, authorized services in an IEP or IFSP.

1) The special transportation is Medicaid reimbursable if:

   a. It is provided to a Medicaid eligible EPSDT child who is a student in a public school in Alabama;
   b. It is being provided on a day when the child receives a prior authorized covered service;
   c. The student's need for specialized transportation services is documented in the child's plan of care, IEP or IFSP; and
   d. The driver has a valid driver's license

2) Specialized transportation services are defined as transportation that requires a specially equipped vehicle, or the use of specialized equipment to ensure a child is taken to and from the child's residence to school or to a community provider's office for prior authorized related services:

   a. Medical Services provided in School: Transportation provided by or under contract with the school, to and from the students place of residence, to the school where the student receives one of the health related services covered by Title XIX;
   b. Medical Service provided off- site: Transportation provided by or under contract with the school from the students place of residence to the office of a medical provider who has a contract with the school to provide one of the health related services covered by the Title XIX;

      i. Transportation from school to the offsite service and back to school is reimbursable. No home to school transportation is reimbursed when the ride is from school to the medical service and back to school.
      ii. Transportation from school to the offsite medical service and to home is reimbursable if the offsite medical appointment takes place and it is not feasible to return to school in time for child to be transported back home.

3) Specialized transportation services will not be Medicaid reimbursable if the child does not receive a Medicaid covered service on the same day. When claiming these costs as direct services, each school district is responsible for maintaining written documentation, such as a trip log, for individual trips provided. No payment will be made to, or for parents providing transportation.

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4) In cases where Personal Care Services are provided as part of the Specialized Transportation Service for a student, the cost of this service is covered under the Personal Care Services benefit described in Section 103.6.5; provided that the personal care service provider meets the qualifications defined in this section.

Procedure Code/ Modifier	***Description***	***Unit of Service***
T2003 U5	Non-emergency transportation; encounter/trip	Per one-way trip

The recommended maximum billable units for procedure code T2003 is a total of four one-way trips per day.

103.7 For More Information

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

Resource	Where to Find It
CMS-1500 Claim Filing Instructions	Chapter 5
Alabama Coordinated Health Network (ACHN)	Chapter 40
EPSDT	Appendix A
Electronic Media Claims (EMC) Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N

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104 Psychiatric Hospital (Recipients 65 & Over)

For purposes of this chapter, an inpatient is a person, age 65 or over, who has been admitted to a free-standing psychiatric facility specializing in the diagnosis, treatment, and care of geriatric patients, for the purpose of maintaining or restoring them to the greatest possible degree of health and independent functioning.

The policy provisions for psychiatric hospitals can be found in the *Alabama Medicaid Agency Administrative Code,* Chapter 5.

104.1 Enrollment

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

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

Federal requirements mandate providers re-validate periodically with the Alabama Medicaid program. Providers will be notified when they are scheduled to re-validate. Failure to re-validate and provide appropriate documentation to complete enrollment will result in an end-date being placed on the provider file. Once a provider file has been closed for failure to timely re-validate, providers will have to submit a new application for enrollment.

National Provider Identifier, Type, and Specialty

A provider who contracts with Alabama Medicaid as a psychiatric hospital is added to the Medicaid system with the National Provider Identifiers provided at the time application is made. Appropriate provider specialty codes are assigned to enable the provider to submit requests and receive reimbursements for psychiatric-related claims.

NOTE:
The 10-digit NPI is required when filing a claim.

Psychiatric hospitals are assigned a provider type of 01 (Hospital). The valid specialty for psychiatric hospitals is Inpatient Psychiatric Hospital Over 65 (011).

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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; or a full-time board certified adult psychiatrist with a minimum of 3 years' experience caring for geriatric patients 65 or older.
- Employ only staff who meet training certification standards in the area of adult 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

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.

Change of Ownership (CHOW) and Closures

Medicaid will mirror Medicare's Change of Ownership (CHOW) policy. Refer to Chapter 19, Hospital for additional information on Change of Ownership.

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. Refer to Chapter 7, Understanding Your Rights and Responsibilities as a Provider, for general criteria on Medical Necessity/ Medically Necessary Care.

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

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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.

Therapeutic visits away from the psychiatric facility to home, relatives, or friends are authorized if certified by the attending physician as medically necessary in the treatment of the recipient. An admission to a general hospital does not count as a therapeutic visit.

- Therapeutic visits may be authorized up to 14 days per admission if certified by the attending physician as medically necessary in the treatment of the recipient. No part of the time spent on any therapeutic leave may be billed to Medicaid.
- Return to inpatient status from therapeutic visits exceeding 14 days per admission will be considered a readmission with the required certification of need for treatment documented in the patient's record.
- Therapeutic visit records will be reviewed retrospectively by the Quality Assurance Division at Medicaid. Providers who have received payments for therapeutic visits will have funds recouped.

NOTE:

A recipient may temporarily transfer to a nursing facility for a two-week trial period. This trial period is not a therapeutic visit. Refer to Chapter 26, Nursing Facility for additional information on admission to a nursing facility from an inpatient psychiatric hospital.

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.

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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

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services to ensure continuity of care with the recipient's family and community service providers upon discharge

The attending or staff physician and other appropriate staff involved in the care of the recipient must review the plan of care at least every 90 days or when significant changes occur in patient functioning or acuity.

The plan of care is evaluated to ensure that the recipient receives treatment that maintains or will restore the patient to the greatest possible level of health and independent functioning.

A written report of the evaluations and the plan of care must be in the individual's record at the time of admission or immediately upon completion of the report if the individual is already in the facility.

Utilization Review (UR) Plan

As a condition of participation in the Alabama Medicaid program, each psychiatric facility must do the following:

- Have in effect a written UR Plan that provides for review of each recipient's need for services that the facility furnishes to the recipient.
- Maintain recipient information required for UR, which includes the certification of need for service and the plan of care.
- Provide a copy of the UR Plan and any subsequent revisions to Medicaid for review and approval.

Provider Preventable Conditions (PPCs)

Provider Preventable Conditions (PPCs) are clearly defined into two separate categories: Healthcare Acquired Conditions and Other Provider Preventable Conditions (OPPCs)

Healthcare Acquired Conditions include Hospital Acquired Conditions (HACs).

OPPCs include but are not limited to the following; surgery on a wrong body part, wrong surgery on a patient, surgery on a wrong patient.

Non- payment of PPCs shall not prevent access to services for Medicaid beneficiaries.

To be reportable, PPCs must meet the following criteria:

- The PPC must be reasonably preventable as determined by a root cause analysis or some other means.
- The PPC must be within the control of the provider.
- The PPC must be clearly and unambiguously the result of a preventable mistake made and hospital procedures not followed, and not an event that could otherwise occur.
- The PPC must result in significant harm. The OPPCs for consideration should be limited to those that yield a serious adverse result. Serious adverse result is defined as one that results in death, a serious disability or a substantial increase in the duration and/or complexity of care that is well beyond the norm for treatment of the presenting condition. A serious disability is defined as a major loss of

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function that endures for more than 30 days, is not present at the time services were sought and is not related to the presenting condition.

- Any process for identifying non-payable events must actively incorporate some element of case-by-case review and determination. While the source and cause of some OPPCs may be clear, most would require further investigation and an internal root cause analysis to determine the cause of the serious preventable event and to assign ultimate accountability.

Pursuant to these guidelines, hospitals will not seek payments for additional days directly resulting from a PPC.

Reporting Other Provider-Preventable Conditions (OPPCs).

The following OPPCs must be reported to Medicaid by encrypted emailing of the required information to:

AdverseEvents@medicaid.alabama.gov. Each hospital will receive a password specifically for e-mail reporting. Reportable "OPPCs" include but are not limited to:

- Surgery on a wrong body part
- Wrong surgery on a patient
- Surgery on a wrong patient

Reports will require the following information: Recipient first and last name, date of birth, Medicaid number, date event occurred and event type.
A sample form is on the Alabama Medicaid Agency website at http://medicaid.alabama.gov/content/4.0_Programs/4.4_Medical_Facilities/4.4.1_Hospital_Services/4.4.1.3_Adverse_Events.aspx
www.medicaid.alabama.gov although hospitals may submit their own form as long as it contains all required information.

NOTE:

***Reporting is required only when not filing a UB-04 claim.**

Reporting Hospital–Acquired Conditions (HAC) and Present on Admission (POA) on the UB-04 Claim Form

Psychiatric hospitals and Psychiatric Residential Treatment Facilities (PRTF's) should use the POA indicator on claims for these HACs as identified by Medicare other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients. If no claim is submitted for the event or the event cannot be filed on a UB-04 claim form, then the Alabama Medicaid Agency is to be notified via encrypted e-mail at AdverseEvents@medicaid.alabama.gov. The following information will be required: Recipient first and last name, date of birth, Medicaid number, date of event occurrence and event type. A sample form can be found on the Alabama Medicaid Agency website or a hospital may submit their own form as long as it contains all of the required

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information. Below are Hospital Acquired Conditions (HACs) with ICD-9 Codes that hospitals are required to report on the UB-04 claim form:

Selected HAC	CC/MCC (ICD-9-CM Codes)	CC/MCC (ICD-10-CM Codes)
Foreign Object Retained After Surgery	998.4 (CC) and 998.7 (CC)	T81.500A to T81.599A T81.60XA to T81.69XA
Air Embolism	999.1 (MCC)	T80.0XXA
Blood Incompatibility	999.60 (CC) 999.61 (CC) 999.62 (CC) 999.63 (CC) 999.69 (CC)	T80.30XA T80.319A T80.310A T80.311A T80.39XA
Pressure Ulcer Stages III & IV	707.23 (MCC) and 707.24 (MCC)	L89.003 to L89.93 L89.004 to L89.94
Falls and Trauma: -Fracture -Dislocation -Intracranial Injury -Crushing Injury -Burn -Electric Shock	Codes within these ranges on the CC/MCC list: 800-829 830-839 850-854 925-929 940-949 991-994	S02.0XXA to T07 S03.0XXA to S91.109A S06.0X0A to S01.90XA S07.0XXA to S77.20XA T26.50XA to T32.99 T33.011A-T70.9XXA
Catheter-Associated Urinary Tract Infection (UTI)	996.64—Also excludes the following from acting as a CC/MCC: 112.2 (CC), 590.10 (CC), 590.11 (MCC), 590.2 (MCC), 590.3 (CC), 590.80 (CC), 590.81 (CC), 595.0 (CC), 597.0 (CC), 599.0 (CC)	T83.51XA B37.41 to B37.49 N10 N10 N15.1 N28.84 to N28.86 N11.9 to N13.6 N16 N30.00 and N30.01 N34.0 N39.0
Vascular Catheter-Associated Infection	999.31 (CC) 999.32 (CC) 999.33 (CC)	T80.218A to T80.219A T80.211A T80.212A
Manifestations of poor glycemic control	250.10-250.13 (MCC), 250.20-250.23 (MCC), 251.0 (CC), 249.10-249.11 (MCC), 249.20-249.21 (MCC)	E10.10 to E13.10 E11.00 to E13.01 E15 E08.00 to E13.10 E08.00 to E13.01
Surgical Site Infection, Mediastinitis, Following Coronary Artery Bypass Graft (CABG)	519.2 (MCC) and one of the following procedure codes: 36.10-36.19.	J98.5 See CMS website for listing of associated Procedure Codes
Surgical Site Infection Following Certain	996.67 (CC) OR 998.59 (CC) and one of the	T84.60XA to T84.7XXA K68.11 to T81.4XXA

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Selected HAC	CC/MCC (ICD-9-CM Codes)	CC/MCC (ICD-10-CM Codes)
Orthopedic Procedures	following procedure codes: 81.01-81.08, 81.23-81.24, 81.31-81.38, 81.83, or 81.85.	See CMS website for listing of associated Procedure Codes
Surgical Site Infection Following Bariatric Surgery for Obesity	Principal Diagnosis code-278.01, 539.01 (CC), 539.81 (CC) OR 998.59 (CC) and one of the following procedure codes: 44.38,44.39, or 44.95	Principal Diagnosis code E6601 and one of the secondary diagnosis codes: K68.11, K9501, K9581 or T81.4XXA See CMS website for listing of associated Procedure Codes
Surgical Site Infection Following Cardiac Implantable Electronic Device (CIED)	996.61 (CC) or 998.59 (CC) And one of the following procedure codes: 00.50, 00.51, 00.52, 00.53, 00.54, 37.80, 37.81, 37.82, 37.83, 37.85, 37.86, 37.87, 37.94, 37.96, 37.98, 37.74, 37.75, 37.76, 37.77, 37.79, 37.89	K68.11, T814XXA. T826XXA, T827XXA See CMS website for listing of associated Procedure Codes
Deep Vein Thrombosis and Pulmonary Embolism Following Certain Orthopedic Procedures	415.11 (MCC), 415.13 (MC) 415.19 (MCC), or 453.40-453.42 and one of the following procedure codes: 00.85-00.87, 81.51-81.52, 81.54.	T80.0XXA to T82.818A I26.90, I2699 I26.09, I26.99 I82.401 to I82.4Z9 See CMS website for listing of associated Procedure Codes
Iatrogenic Pneumothorax with Venous Catheterization	512.1 (CC) And the following procedure code 38.93	J95.811 and one of the following procedure codes: 05HM33Z

For ICD-10, please use the CMS Diagnosis Listing for POA Exempt Diagnosis Codes at: https://www.cms.gov/Medicare/Coding/ICD10/index.html

Select the appropriate fiscal year ICD-10-CM POA Exempt file for the dates of service of the claim. These codes are for recipient encounters occurring between October 1st through September 30th of each fiscal year.

All Diagnosis codes NOT present in the listing require POA indicator.

The psychiatric hospital or PRTF may use documentation from the physician's qualifying diagnoses to identify POA which must be documented within 72 hours of the occurrence. Medicaid also recommends that the event be reported to Medicaid on the claim or via e-mail within 45 days of occurrence.

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Non-payment of provider preventable conditions shall not prevent access to services for Medicaid beneficiaries.

No reduction in payment for a PPC will be imposed on a hospital provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider.

Reductions in Provider payment may be limited to the extent that the following apply:

- The Identified PPC would otherwise result in an increase in payment.
- Psychiatric hospitals and PRTF's are paid based on a daily per diem rate. It is the responsibility of the hospital to identify any Health Care-Acquired Condition and not seek payment for any additional days that have lengthened a recipient's stay due to a PPC.

  In reducing the amount of days: Hospitals are to report a value code of '81' on the UB-04 claim form along with any non-covered days and the amount field must be greater than '0'.

It is the responsibility of the psychiatric hospital or PRTF to identify these events, report them, and not seek any additional payment for additional days. Medicaid will accept all POA indicators as listed below:

- **Y**-Yes. Diagnosis was present at time of inpatient admission.
- **N**-No. Diagnosis was not present at time of inpatient admission.
- **U**-No information in the record. Documentation insufficient to determine if the condition was present at the time of inpatient admission.
- **W**-Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission.

It is the psychiatric hospital or RTF's responsibility to include all supporting documentation with the chart for a review to be conducted by Medicaid's contracted Quality Improvement Organization (QIO). Submission of a root cause analysis is not required but may be submitted as part of the documentation to support billing.

A document with frequently asked questions has been posted on the Agency's website under Programs/Hospital Services.

Payment

Payment for inpatient services provided by psychiatric facilitates for individuals age 65 and older shall be the per diem rate established by Medicaid for the hospital. The per diem rate is based on the Medicaid cost report and all the requirements expressed in the *Alabama Medicaid Administrative Code,* Chapter 23. Ancillary charges (lab, x-ray, etc.) may not be billed in addition to the facility per diem rate.

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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 Inpatient Utilization Review

1. The determination of the level of care will be made by a licensed nurse of the hospital staff.
2. Five percent of all admissions and concurrent stay charts will be retrospectively reviewed by the Medicaid Agency or designee on a monthly basis.
3. For an individual who applies for Medicaid while in the facility, a Psychiatric Admission form must be signed by the attending physician at the time application for Medicaid is made.
4. The following information shall be included on the Psychiatric Admission Form:
   (a) Recipient information:
      1. Admitting diagnosis;
      2. Events leading to hospitalization;
      3. History of psychiatric treatment;
      4. Current medications;
      5. Physician orders;
      6. Presenting signs and symptoms.
   (b) Events leading to present hospitalization
   (c) History and physical
   (d) Mental and physical capacity
   (e) Summary of present medical findings including prognosis
   (f) Plan of care.

104.4 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

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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.

104.5 Cost Sharing (Copayment)

The copayment amount for an inpatient admission (including crossovers) is $50.00 per admission. Copayment does not apply to services provided for pregnant women, nursing home residents, recipients less than 18 years of age, emergencies, or family planning. Native American Indians that present an “active user letter” issued by Indian Health Services (IHS) will be exempt from the Medicaid required copayment.

The provider may not deny services to any eligible Medicaid recipient because of the recipient’s inability to pay the cost-sharing (copayment) amount imposed.

NOTE:

Copayment is not a third party resource. Do not record copayment on the UB-04.

104.6 Completing the Claim Form

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-04 claim form must be submitted.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

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104.6.1 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.

104.6.2 Diagnosis Codes

The *International Classification of Diseases - 10th Revision - Clinical Modification* (ICD-10-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, AMA Plaza 330 North Wabash Ave, Suite 39300 Chicago, IL 60611-5885, or 1-800-621-8335.

NOTE:

ICD-9 codes should be used for claims submitted with dates of service prior to or equal to 09/30/2015.

ICD-10 codes should be used for claims submitted with dates of service on/after 10/01/2015.

NOTE:

ICD-9 or ICD-10 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

104.6.3 Revenue Codes

Refer to the Alabama UB-04 Manual, published by the Alabama Hospital Association, for a complete list of revenue codes.

104.6.4 Place of Service Codes

Place of service codes do not apply when filing the UB-04 claim form.

104.6.5 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 5.8, Required Attachments, for more information on attachments.

104.7 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
UB-04 Claim Filing Instructions	Chapter 5
Medical Necessity/Medically Necessary Care	Chapter 7
Electronic Media Claims (EMC) Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N

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105

105 Rehabilitative Services – DMH, DHR, DYS, DCA

Rehabilitative services are specialized medical services delivered by uniquely qualified practitioners designed to treat or rehabilitate persons with mental illness, substance abuse, or co-occurring mental illness and substance abuse diagnoses. These services are provided to recipients on the basis of medical necessity.

Direct services may be provided in the recipient'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 recipient and staff member, that affords an adequate therapeutic environment, and that protects the recipient's rights to privacy and confidentiality.

Rehabilitative services will be provided to Medicaid recipients on the basis of medical necessity. Although limits are provided for guidance, the limitation(s) noted can be exceeded based on medical necessity. While it is recognized that involvement of the family in the treatment of individuals with mental illness or substance use disorders is necessary and appropriate, provision of services where the family is involved clearly must be directed to meeting the identified recipient's treatment needs. Services provided to non-Medicaid eligible family members independent of meeting the identified recipient's treatment needs are not covered by Medicaid. An asterisk denoting this restriction will appear in each service description that makes reference to a recipient's collateral defined as a family member, legal guardian or significant other. Rehabilitation services that are delivered face to face can either be in person or via telemedicine/telehealth, as approved by the Alabama Medicaid Agency.

The policy provisions for rehabilitative services providers can be found in the *Alabama Medicaid Agency Administrative Code,* Chapter 47.

105.1 Enrollment

Gainwell 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.

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Federal requirements mandate providers re-validate periodically with the Alabama Medicaid program. Providers will be notified when they are scheduled to re-validate. Failure to re-validate and provide appropriate documentation to complete enrollment will result in an end-date being placed on the provider file. Once a provider file has been closed for failure to timely re-validate, providers will have to submit a new application for enrollment.

National Provider Identifier, Type, and Specialty

A provider who contracts with the Alabama Medicaid Agency as a rehabilitative services provider is added to the Medicaid system with the National Provider Identifiers provided at the time application is made. Appropriate provider specialty codes are assigned to enable the provider to submit requests and receive reimbursements for rehabilitation-related claims.

NOTE:

The 10-digit NPI is required when filing a claim.

Rehabilitative services providers are assigned a provider type of 11 (State Rehabilitative Services). The valid specialties for State Rehabilitative Services are:

- Rehabilitative Services - DMH (111)
- Rehabilitative Services – DHR, DYS, DCA (118)
- Psychiatry (Psychiatrist only) (339)

Enrollment Policy for Rehabilitative Services Providers

To participate in the Alabama Medicaid Program, rehabilitative services providers must meet the following requirements. Service providers must demonstrate that they meet the criteria in either (1), (2), OR (3) and both (4) AND (5) below.

1. A provider must be certified as a 310-board community mental health center by DMH and must have demonstrated the capacity to provide access to the following services through direct provision or referral arrangements:
    - Inpatient services through referral to community hospitals and through the attending physician for community hospitalizations
    - Substance abuse services including intensive outpatient services and residential services
    - Must submit an application to and receive approval from DMH to provide mental health rehabilitative services under the Medicaid Rehabilitative Option program.
2. For the provision of Substance Abuse Rehabilitative Services an entity:
    - Must be an organization that is currently certified by the Alabama Department of Mental Health (DMH) to provide alcohol and other drug treatment services under the provisions of Chapter 580 of the Alabama Administrative Code; and

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- Must submit an application to and receive approval by DMH to provide Substance Abuse Rehabilitative Services under the Medicaid Rehabilitative Option program.

3. The Department of Human Resources (DHR), the Department of Youth Services (DYS), and the Department of Children's Services (DCA) are eligible to be rehabilitative services providers for children under age 21 if they have demonstrated the capacity to provide an array of medically necessary services, either directly or through contract.

   Additionally, DHR may provide these services to adults in protective service status. At a minimum, this array includes the following:

   - Individual, group, and family counseling
   - Crisis intervention services
   - Consultation and education services
   - Case management services Assessment and evaluation

4. A provider must demonstrate the capacity to provide services off-site in a manner that assures the recipient's right to privacy and confidentiality and must demonstrate reasonable access to services as evidenced by service location(s), hours of operation, and coordination of services with other community resources.

5. A provider must ensure that Medicaid recipients receive quality services in a coordinated manner and have reasonable access to an adequate array of services delivered in a flexible manner to best meet their needs. Medicaid does not cover all services listed above, but the provider must have demonstrated the capacity to provide these services.

105.1.1 Minimum Qualifications for Rehabilitative Services Professional Staff (DMH/DHR/DYS)

A Rehabilitative Services Professional is defined as the following:

- Rehabilitative Services Professional:
- A psychologist licensed under Alabama law
- A professional counselor licensed under Alabama law
- An associate licensed counselor under Alabama law
- An independent Clinical social worker licensed under Alabama law
- A licensed master social worker licensed under Alabama law
- A marriage and family therapist licensed under Alabama law
- A marriage and family therapist associate licensed under Alabama law
- A registered nurse licensed under Alabama law who has completed a master's degree in psychiatric nursing
- A Masters Level Clinician is 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 human service field areas and is under the supervision of a master's level or above clinician with two years of postgraduate clinical experience.

Added: An associate licensed…under Alabama law
Deleted: ~~certified~~
Added: licensed master
Added: A marriage and…under Alabama law

Deleted: ~~who meets at…postgraduate clinical experience~~
Added: and is under…postgraduate clinical experience

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- QSAP I (Substance Abuse): A Qualified Substance Abuse Professional I shall consist of: (i) An individual licensed in the State of Alabama as a: (I) Professional Counselor, Graduate Level Social Worker, Psychiatric Clinical Nurse Specialist, Psychiatric Nurse Practitioner, Marriage and Family Therapist, Clinical Psychologist, Physician's Assistant, Physician; or (ii) An individual who: (I) Has a master's Degree or above from a nationally or regionally accredited university or college in psychology, social work, counseling, psychiatric nursing, and * (II) Has successfully completed a clinical practicum or has six month's post master's clinical experience; and * (III) Holds a substance abuse counselor certification credential from the Alabama Association of Addiction Counselors, National Association of Alcoholism and Drug Abuse Counselors, Alabama Alcohol and Drug Abuse Association, or International Certification and Reciprocity Consortium/Alcohol and Other Drug Abuse, Inc. which shall be obtained within thirty (30) months of date of hire.

105.1.2 Minimum Qualifications for Rehabilitative Services Other Eligible Service Providers (DMH Mental Illness, DMH Substance Abuse, DHR, and DYS)

Rehabilitative Services Mental Illness Professional Staff Other Eligible Service Providers qualifications are as follows (in addition to the practitioners listed in Section 105.1.1):

- A physician licensed under Alabama law
- A physician assistant licensed under Alabama law and practicing within the guidelines as outlined by the Alabama Board of Medical Examiners
- A Certified Registered Nurse Practitioner (CRNP) licensed under Alabama law practicing within the scope as defined by the Joint Committee of the Alabama Board of Nursing and the Alabama Board of Medical Examiners for Advanced Practice Nurses or multistate licensure privilege
- A pharmacist licensed under Alabama state law may provide medication monitoring
- A Registered Nurse licensed under Alabama state law
- A Practical Nurse licensed under Alabama state law
- Qualified Mental Health Provider – Bachelor's – A person with a Bachelor's Degree in a human services field
- Qualified Mental Health Provider– Non-Degreed – A person with a high school diploma or GED supervised by a Rehabilitative Services Professional
- A Nursing Assistant certified pursuant to Alabama State Law.
- A Certified Medical Assistant certified through the American Association of Medical Assistants (AAMA) or the American Medical Technologists (AMT).
- Medication Assistant Certified (MAC) Worker – A person working under a Medication Assistance Supervising (MAS) nurse that meets the Alabama Board of Nursing requirements.
- A Certified Mental Health Youth Peer Specialist - Youth who has personal verified lived experience with children and adolescent's mental health, who is willing to share his/her personal experiences,

Deleted: ~~to practice medicine or osteopathy~~

Added: or a multistate licensure privilege

Added: A Certified Medical…American Medical Technologists (AMT).

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who has at least a high school diploma or GED, and who has satisfactorily completed a Mental Health Youth Peer Specialist training program approved by the state within six (6) months of date of hire. Certified Mental Health Peer Specialist must be supervised by a Rehabilitative Services Professional.

- A Certified Mental Health Adult Peer Specialist who has personal verified lived experience with recovery from mental illness, who is willing to share his/her personal experiences, who has at least a high school diploma or GED, and who has satisfactorily completed a Mental Health Peer Specialist training program approved by the state within six (6) months of date of hire. A Mental Health Certified Adult Peer Specialist must be supervised by a Rehabilitative Services Professional.
- A Mental Health Youth Parent Peer Support Specialist provider who is parenting or has parented a child experiencing mental, emotional or behavioral health disorders and can articulate the understanding of their lived experience with another parent or family member. This individual may be a birth parent, adoptive parent, family member standing in for an absent parent, or other person chosen by the family or youth to have the role of parent. This individual has at least a high school diploma or GED and has satisfactorily completed a Mental Health Youth Parent Peer Support Provider training program approved by state within six (6) months of date of hire. A Mental Health Youth Parent Peer Support Specialist must be supervised by a Rehabilitative Services Professional.

Rehabilitative Other Eligible Services Substance Abuse Service Providers are as follows (in addition to the practitioners listed in Section 105.1.1):

- QSAP II shall consist of: (i) An individual who: (I) Has a Bachelor's Degree from a nationally or regionally accredited university or college in psychology, social work, community-rehabilitation, pastoral counseling, family therapy, or other behavioral health area that requires equivalent clinical course work, and (II) Is licensed in the State of Alabama as a Bachelor Level Social Worker; or (III) Has a Bachelor's Degree from a nationally or regionally accredited college or university in psychology, social work, community-rehabilitation, pastoral counseling, family therapy, or other behavioral health area that requires equivalent clinical course work, and (IV) Holds a substance abuse counselor certification credential from the Alabama Association of Addiction Counselors, National Association of Alcoholism and Drug Abuse Counselors, Alabama Alcohol and Drug Abuse Association, or International Certification and Reciprocity Consortium.
- QSAP III shall consist of: (i) An individual who: (I) Has a Bachelor's Degree from a nationally or regionally accredited university or college in psychology, social work, community-rehabilitation, pastoral counseling, family therapy, or other behavioral health area that requires equivalent clinical course work, and (II) Participates in ongoing supervision by a certified or licensed QSAP I for a minimum of one (1) hour individual per week until attainment of a substance abuse counselor certification credential from the Alabama Association of Addiction Counselors, National Association of Alcoholism and Drug Abuse Counselors, or Alabama Alcohol and Drug Abuse Association,

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or International Certification and Reciprocity Consortium/Alcohol and Other Drug Abuse, Inc. which shall be obtained within thirty (30) months of hire.

- Qualified Paraprofessionals (QPP) shall have the following minimum qualifications: (i) A high school diploma or equivalent, and (ii) One (1) year of work experience directly related to job responsibilities and (iii) Concurrent participation in clinical supervision by a licensed or certified QSAP I.
- Certified Recovery Support Specialist (CRSS) must meet the following minimum qualifications: (i) Certified by ADMH as a Certified Recovery Support Specialist (CRSS) within six (6) months of date of hire, (ii) and has 2 years verified lived experience and (iii) Concurrent participation in clinical supervision by a licensed or certified QSAP I.
- A Certified Registered Nurse Practitioner (CRNP) licensed under Alabama law practicing within the scope as defined by the Joint Committee of the Alabama Board of Nursing and the Alabama Board of Medical Examiners for Advanced Practice Nurses
- A Pharmacist licensed under Alabama state law.
- A Registered Nurse licensed under Alabama state law or multistate licensure privilege.
- A Practical Nurse licensed under Alabama state law or multistate licensure privilege.
- Medication Assistant Certified (MAC) Worker – A person working under a Medication Assistance Supervising (MAS) nurse that meets the Alabama Board of Nursing requirements.

Added: or multistate licensure privilege

Added: or multistate licensure privilege

Rehabilitative Services DHR/DHR Adult Protective Services Professional Staff qualifications are as follows (in addition to the practitioners listed in Section 105.1.1 and Other Eligible Mental Illness Service Providers above)

- A physician licensed under Alabama law to practice medicine or osteopathy
- A physician assistant licensed under Alabama law and practicing within the guidelines as outlined by the Alabama Board of Medical Examiners
- A pharmacist licensed under Alabama state law may provide medication monitoring
- Senior Social Work Supervisor – Master's degree in Social Work from a social work program accredited by the Council on Social Work Education. Two years of professional social work experience in child welfare and/or adult services in a public welfare agency.
- Service Supervisor – Bachelor's degree from an accredited* four year college or university in any major AND three (3) years of professional social work experience in child protective services, adult protective services, child/adult foster care, and/or adoption operations OR Bachelor's degree from an accredited* four year college or university AND 30 semester or 45 quarter hours in social or behavioral science courses AND two (2) years of professional social work experience in child protective services, adult protective services, child/adult foster care, and/or adoption operations. A Master's Degree in Social Work from a social work program accredited* by the Council on Social Work Education will substitute for one year of the required professional

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experience in child protective services, adult protective services, child/adult foster care, and/or adoption operations.

- Senior Social Worker - Master's degree in Social Work from a social work program accredited by the Council on Social Work Education. Eligibility for Licensure as issued by the Alabama Board of Social Work Examiners.
- Social Worker - Bachelor's degree in Social Work from a social work program accredited by the Council on Social Work Education. Eligibility for Licensure as issued by the Alabama Board of Social Work Examiners
- Social Service Caseworker- Bachelor's degree from an accredited* college or university in any major.

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. Refer to Chapter 7, Understanding Your Rights and Responsibilities as a Provider, for general criteria on Medical Necessity/ Medically Necessary Care.

Treatment eligibility is limited to individuals with a primary diagnosis within the range of F0150-F69 and F90-F99 for ICD-10, assigned by a licensed physician, a licensed psychologist, a licensed physician's assistant, a certified nurse practitioner, or a licensed professional counselor of mental illness or substance abuse as listed in the most current International Classification of Diseases - 10th Revision - Clinical Modification (ICD-10-CM). Medicaid will cover diagnostic testing, status exam even if the resulting diagnosis is intellectual/developmental disability secondary to a primary mental health diagnoses. Medicaid does not cover the Z codes for adult treatment services; however, it does cover intake evaluation, crisis intervention, the behavioral health placement assessment needs, and diagnostic assessment even if the resulting diagnosis is a Z code. For treatment services provided to children under 21, or those adults receiving DHR protective services, the only Z code Medicaid covers for reimbursement is Z65.9 unspecified psychosocial circumstance.

105.2.1 Covered Services

While Medicaid recognizes that family involvement in the treatment of individuals in need of rehabilitative services is necessary and appropriate, provision of services where the family is involved clearly must be directed to meeting the recipient's treatment needs. Medicaid does not cover services for non-Medicaid eligible family members independent of meeting the recipient's treatment needs.

Only the following rehabilitative services qualify for reimbursement under this program:

- Intake Evaluation
- Medical Assessment and Treatment
- Diagnostic Testing
- Crisis Intervention

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- Individual Counseling
- Family Counseling
- Group Counseling
- Medication Administration
- Medication Monitoring
- Partial Hospitalization Program
- Adult Intensive Day Treatment
- Adult Rehabilitative Day Program
- Child and Adolescent Mental Illness Day Treatment
- Treatment Plan Review
- Mental Health Care Coordination
- Adult In-home Intervention
- Child and Adolescent In-Home Intervention
- Mental Health and Substance Use Disorders Update
- Behavioral Health Placement Assessment
- Basic Living Skills
- Psychoeducational Services
- Assertive Community Treatment (ACT)
- Program for Assertive Community Treatment (PACT)
- Opioid Use Disorder Treatment
- Child and Adolescent Peer Support Services
- Adult Peer Support Services
- Youth Peer Support Services
- Family Peer Support Services
- Psychosocial Rehabilitation Services – Working Environment
- Screening
- Brief Intervention
- Nursing Assessment and Care
- Outpatient Detoxification
- Therapeutic Mentoring

This section contains a complete description of each covered service along with benefit limitations.

Services must be provided in a manner that meets the supervisory requirements of the respective certifying authority or as authorized by state law.

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Telehealth Billing Guidelines

Refer to Chapter 112, Telemedicine Services, for general benefit information and limitations.

Intake Evaluation (90791-HE 90791-HF)

HE = Mental Illness HF = Substance Abuse

Definition

Initial clinical evaluation of the recipient's request for assistance. Substance abuse recipients undergo standardized psychosocial assessment. The intake evaluation presents psychological and social functioning, recipient's reported physical and medical condition, the need for additional evaluation and/or treatment, and the recipient's fitness for rehabilitative services.

Key service functions include the following:

- A clinical interview with the recipient and/or collateral
- Screening for needed medical, psychiatric, or neurological assessment, as well as other specialized evaluations
- A brief mental status evaluation
- Review of the recipient's presenting problem, symptoms, functional deficits, and history
- Initial diagnostic formulation
- Development of an initial plan for subsequent treatment and/or evaluation
- Referral to other medical, professional, or community services as indicated

Eligible Provider Type -- DMH Mental Illness/DMH Substance Abuse

Clinical evaluation and assessments of a recipient may be performed by a person who possesses any one or more of the following qualifications:

- Rehabilitative Services Professional (all types)

Eligible Provider Type – DYS

- Rehabilitative Services Professional as defined in 105.1.1

Eligible Provider Type – DHR

- Rehabilitative Services Professional (all types)
- Social Services Caseworker

Eligible Provider Type – DHR / DHR Adult Protective Services

Services may be provided by an individual employed by a public provider department who meets the state merit system qualifications for Social Service Caseworker or above, or an employee of an agency or entity under contract to serve the target population of one of the same public provider agencies who meets an approved equivalency for Social Service Caseworker, or above.

Billing Unit: Episode

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Maximum Units:	Unlimited (Mental Illness) 1 per year (Substance Abuse)
Billing Restrictions:	May not be billed in combination with Treatment Plan Review (H0032), Individual Counseling (90832-HF, 90834-HF, 90837-HF), Group Counseling (90853-HF), Family Counseling (90846-HF, 90847-HF), Multi Family Group Psychotherapy (90849-HF).

Location

Services can be delivered in any setting that is convenient for both the recipient and staff member, that affords an adequate therapeutic environment and that protects the recipient's rights to privacy and confidentiality, to include inpatient hospitals and inpatient psychiatric residential facilities.

Additional Information

An intake evaluation must be performed for each recipient considered for initial entry into a treatment program. This requirement applies to any organized program or course of covered services that a recipient 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 recipient'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 recipient 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.) that includes elements defined, completed by the fifth face-to-face outpatient client visit or within ten working days after admission in all day programs or residential program for mental illness recipients; and, completed by the tenth day after admission to an outpatient program or by the fifth day after admission to a residential program, prior to provision of SA treatment services, except as noted below, or within other time limits that may be specified under program specific requirements. The treatment plan will do the following:

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- Identify the clinical issues that will be the focus of treatment.
- Specify those services necessary to meet the recipient's needs.
- Include referrals as appropriate for needed services not provided directly by the agency.
- Identify expected processes/outcomes toward which the recipient and therapist will be working to impact upon the specific clinical issues.
- Be approved in writing by a licensed psychologist, graduate level certified licensed social worker, licensed professional counselor, a licensed marriage and family therapist, a Certified Registered Nurse Practitioner (CRNP) licensed under Alabama law practicing within the scope as defined by the Joint Committee of the Alabama Board of Nursing and the Alabama Board of Medical Examiners for Advanced Practice Nurses, a registered nurse licensed under Alabama law with master's degree in psychiatric nursing, a physician licensed under Alabama law, or a physician assistant licensed under Alabama law and practicing within the guidelines as outlined by the Alabama Board of Medical Examiners. For SA services, the patient, counselor, and licensed staff as noted above must all approve the treatment plan prior to the provision of SA treatment services.
- Except as noted above face-to-face services may be provided and billed between the initial Intake service and the development of the treatment plan within the allowed time frames. Once the Treatment Plan is developed, service types must be specified in the treatment plan in order to be paid by Medicaid, with the exception of crisis intervention and resolution, mental health care coordination, behavioral health placement assessment, and treatment plan review. Changes in the treatment plan must be approved by a person licensed under Alabama law to practice psychology, certified social work, professional counseling, marriage and family therapy, or medicine; or a registered nurse licensed under Alabama law with master's degree in psychiatric nursing. For child and adolescent services or adults receiving DHR protective services, the person who approves the treatment plan must meet the criteria in Requirements for Recipient Intake, Treatment Planning, and Service Documentation section.
- For DMH Mental Illness providers, Z04.6 is covered for this service.

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Medical Assessment and Treatment (H0004-HE H0004-HF)

Definition

Contact with a recipient during which a qualified practitioner provides psychotherapy and/or medical management services. Services may include physical examinations, evaluation of co-morbid medical conditions, development or management of medication regimens, the provision of insight oriented, behavior modifying, supportive, or interactive psychotherapeutic services, or the provision of educational services related to management of a physical, mental health, or substance use disorder.

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 Provider Type -- (All Agencies)

Physician medical assessment and treatment may be performed by a physician licensed under Alabama law to practice medicine or osteopathy, a physician assistant licensed under Alabama law and practicing within the guidelines as outlined by the Alabama Board of Medical Examiners, or a Certified Registered Nurse Practitioner (CRNP) licensed under Alabama law practicing within the scope as defined by the Joint Committee of the Alabama Board of Nursing and the Alabama Board of Medical Examiners for Advanced Practice Nurses.

Billing Unit:	15 minutes
Maximum Units:	6 per day, 52 per year
Billing Restrictions:	May not be billed in combination with Partial Hospitalization (H0035), ACT (H0040), PACT (H0040-HQ), Outpatient Detoxification – Ambulatory Detoxification With Extended On-Site Monitoring (II-D) (H0013), Outpatient Detoxification – Ambulatory Detoxification Without Extended On-Site Monitoring (I-D) (H0014).

Location

The only excluded settings are hospitals. Services can be delivered in any setting that is convenient for both the recipient and staff member, that affords an adequate therapeutic environment, and that protects the recipient's rights to privacy and confidentiality.

Additional Information

All services rendered by a physician, physician assistant, or nurse practitioner that meet the definition above should be billed under this code including those rendered via teleconference with a direct service or consultation recipient. Please refer to the section titled **Telehealth Billing Guidelines** for more information.

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Diagnostic Testing done by physician or psychologist (96130-HE 96130-HF 96131-HE 96131-HF 96136-HE 96136-HF, 96137-HE 96137-HF)

(Previously 96101)

Definition

Psychological testing evaluation services by physician or other qualified health care professional,
including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report and interactive feedback to the patient, family member(s) or caregiver(s), when performed; **first hour** in a face-to-face (in person or via telemedicine) interaction between the recipient and the psychologist or psychiatrist and interpretation of the test results to assist with a definitive diagnosis. Once the diagnosis has been confirmed, this information is used to guide proper treatment by the development of an individualized, person-centered treatment plan.

Eligible Staff – All State Agencies

Procedure codes 96130, 96131, 96137, 96138 -Diagnostic testing may only be performed by:

- A psychiatrist licensed under Alabama law

OR

- A psychologist licensed under Alabama law

Billing Unit:	One hour (96130, 96131)
	Thirty Minutes (96136, 96137)
Maximum Units:	96130 1 per year 96131 7 per year
	96136 1 per year, 96137 11 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 recipient and staff member, that affords an adequate therapeutic environment, and that protects the recipient's rights to privacy and confidentiality.

Additional Information

Professional and Technical Activities Performed by the Psychologist
Please note that the new codes **do not** crosswalk on a one-to-one basis with the deleted codes. The single code, 96101, will now be billed using up to four (4) codes; two (2) codes for Psychological Evaluation Services (96130, 96131) and two (2) for Test Administration and Scoring (96136, 96137).

- Evaluation services include interpretation of test results and clinical data, integration of patient data, clinical decision-making, treatment planning, report generation, and interactive feedback to the patient, family member(s) or caregiver(s).

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  - The **first hour** of psychological evaluation is billed using 96130 and **each additional hour** needed to complete the service is billed with the add-on code 96131.
  - CPT Time Rules allow an additional unit of a time-based code to be reported as long as the mid-point of the stated amount of time is passed. Beyond the first hour (96130), at least an additional 31 minutes of work must be performed to bill the first unit of the add-on code 96131.

- Evaluation services must always be performed by the professional prior to test administration, and must be billed on the last date of service, but documented in the medical record the actual date(s) the service is performed.
- Test administration and scoring services **performed by the psychologist** includes time spent to administer and score a minimum of two (2) psychological tests.
  - The first **30 minutes** of test administration and scoring is billed using 96136 and **each additional 30-minute** increment needed to complete the service is billed with code 96137.
  - CPT time rules apply to the add-on code if, beyond the first 30 minutes, at least an additional 16 minutes of work is performed.

Diagnostic testing may be billed at any time during treatment so long as the annual cap is not exceeded.

The time started and time ended of service delivery will not include time spent for scoring, interpretation and report writing (at this time). Billing should reflect the **total** time for face-to-face (in person or via telemedicine) administration, scoring, interpretation and report writing. The test(s) given on the date of service billed must be documented in the treatment note for post payment review purposes.

Intellectual Disability and Developmental Disability/Autism Spectrum diagnosis codes (ICD-10 F70-F89) are not covered for treatment services; however, Medicaid will cover diagnostic testing, status exam (96130/96131, 96136/96137,96138/96139, 96116 and 96146), even if the resulting diagnosis is intellectual/developmental disability secondary to a primary mental health diagnoses.

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Diagnostic Testing done by technician (96130-HE 96130-HF 96131-HE 96131-HF 96138-HE 96138-HF 96139-HE 96139-HF) {Previously 96102}

Definition

Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report and interactive feedback to the patient, family member(s) or caregiver(s), when performed; **first hour** in a face-to-face (in person or via telemedicine) interaction between the recipient and the technician and interpreted by a qualified health care professional to assist with a definitive diagnosis. Once the diagnosis has been confirmed, this information is used to guide proper treatment by the development of an individualized, person-centered treatment plan.

Eligible Staff – DMH Mental Illness, DHR/DYS/DCA Child and Adolescent Services, DHR Adult Protective Services

Procedure codes 96130, 96131, 96138, 96139 -Diagnostic testing may be performed by: a person who possesses any one or more of the following qualifications:

- Rehabilitative Services Professional licensed, (operating within their scope of practice)
- 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 human service field areas 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 – DMH Substance Abuse Services

Procedure codes 96130, 96131, 96138, 96139 - Diagnostic testing may be performed by a Rehabilitative Services Professional as consistent with the individual's training, experience and the scope of practice established by his/her respective professional discipline and Alabama law.

Billing Unit:	One hour (96130, 96131)
	Thirty Minutes (96138, 96139)
Maximum Units:	96130 1 per year 96131 7 per year
	96138 1 unit per year 96139 11 units 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 recipient and staff member, that affords

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an adequate therapeutic environment, and that protects the recipient's rights to privacy and confidentiality.

Additional Information

Professional Services Performed by the Psychologist and Technical Services Performed by Technician

Please note that the new codes **do not** crosswalk on a one-to-one basis with the deleted codes. The single code, 96101, will now be billed using up to four (4) codes; two (2) codes for Psychological Evaluation Services (96130, 96131) and two (2) for Test Administration and Scoring (96138, 96139).

- Psychological Evaluation services include interpretation of test results and clinical data, integration of patient data, clinical decision-making, treatment planning, report generation, and interactive feedback to the patient, family member(s) or caregiver(s).
    - The first **hour** of psychological evaluation is billed using 96130 **and each additional hour** needed to complete the service is billed with the add-on code 96131.
    - CPT Time Rules allow an additional unit of a time-based code to be reported as long as the mid-point of the stated amount of time is passed. Beyond the first hour (96130), at least an additional 31 minutes of work must be performed to bill the first unit of the add-on code 96131.
- Evaluation services must always be performed by the professional prior to test administration, and must be billed on the last date of service, but documented in the medical record the actual date(s) the service is performed.
- Test administration and scoring services **performed by the Technician** includes time spent to administer and score a minimum of two (2) psychological tests.
    - The first **30 minutes** of test administration and scoring is billed using 96138 and **each additional 30-minute** increment needed to complete the service is billed with code 96139.
    - CPT time rules apply to the add-on code if, beyond the first 30 minutes, at least an additional 16 minutes of work is performed.

Diagnostic testing may be billed at any time during treatment so long as the annual cap is not exceeded.

Intellectual Disability and Developmental Disability/Autism Spectrum diagnosis codes (ICD-10 F70-F89) are not covered for treatment services; however, Medicaid will cover diagnostic testing, status exam (96130/96131, 96136/96137,96138/96139, 96116 and 96146), even if the resulting diagnosis is intellectual/developmental disability secondary to a primary mental health diagnoses.

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Diagnostic Testing administered by a computer (96146-HE 96146-HF) {Previously 96103}

Definition

Psychological or neuropsychological test administration, with single automated instrument via electronic platform, with automated result only

Eligible Staff – DMH Mental Illness, DMH Substance Abuse, DHR/DYS/, DHR Adult Protective Services

Diagnostic testing-procedure code 96146 must be administered by a computer and interpreted by a *computer.*

Billing Unit:	One
Maximum Units:	1 per year
Billing Restrictions:	None

Location

The only excluded settings are hospitals. Services can be delivered in any setting that is convenient for both the recipient and staff member, that affords an adequate therapeutic environment, and that protects the recipient'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.

Intellectual Disability and Developmental Disability/Autism Spectrum diagnosis codes (ICD-10 F70-F89) are not covered for treatment services; however, Medicaid will cover diagnostic testing, status exam (96130/96131, 96136/96137,96138/96139, 96116 and 96146), even if the resulting diagnosis is intellectual/developmental disability secondary to a primary mental health diagnoses.

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Crisis Intervention (H2011-HE)

Definition

Immediate emergency intervention with a recipient, or the recipient's collateral* (in person or by telephone) to ameliorate a maladaptive emotional/behavioral reaction by the recipient. Service is designed to resolve crisis and develop symptomatic relief, increase knowledge of resources to assist in mitigating a future crisis, and facilitate return to pre-crisis routine functioning. Interventions include a brief, situational assessment; verbal interventions to de-escalate the crisis; assistance in immediate crisis resolution; mobilization of natural and formal support systems; and referral to alternate services at the appropriate level.
Key service functions include the following:

- Specifying factors that led to the recipient's crisis state, when known
- Identifying the maladaptive reactions exhibited by the recipient
- Evaluating the potential for rapid regression
- Resolving the crisis
- Referring the recipient for treatment at an alternative setting, when indicated

Eligible Provider Type – DMH Mental Illness/DMH Substance Abuse

Crisis intervention and resolution may be performed by a person who possesses any one or more of the following qualifications:

- Rehabilitative Services Professional (all types)
- Licensed Registered Nurse
- Licensed Practical Nurse
- Certified Nursing Assistant
- Qualified Mental Health Provider – Bachelor's
- Social Service Caseworker (DHR only)
- Certified Mental Health Peer Specialist (Youth, Adult, and Parent)
- QSAP II (DMH Substance Abuse only)
- QSAP III (DMH Substance Abuse only)
- Certified Recovery Support Specialist (CRSS) (DMH Substance Abuse only)

Eligible Provider Type - DYS

Crisis intervention and resolution may be performed by a person who possesses any one or more of the following qualifications:

- Rehabilitative Services Professional as defined in 105.1.1
- Licensed Registered Nurse

Eligible Provider Type - DHR/ DHR Adult Protective Services

Services may be provided by an individual employed by a public provider department who meets the state merit system qualifications for Social Service Caseworker or above, or an employee of an agency or entity under contract

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to serve the target population of one of the same public provider agencies who meets an approved equivalency for Social Service Caseworker, or above.

Billing Unit:	15 minutes
Maximum Units:	20 per day, 7300 per calendar year
Billing Restrictions:	MI: May not be billed in combination with In-Home Intervention (H2021,H2022-HA), ACT(H0040), PACT (H0040-HQ) SA: May not be billed in conjunction with Opioid Use Disorder Treatment (H0020), Outpatient Detoxification – Ambulatory Detoxification With Extended On-Site Monitoring (II-D) (H0013), Outpatient Detoxification – Ambulatory Detoxification Without Extended On-Site Monitoring (I-D) (H0014)

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Location

The only excluded settings are hospitals. Services can be delivered in any setting that is convenient for both the recipient and staff member, that affords an adequate therapeutic environment, and that protects the recipient's rights to privacy and confidentiality.

Additional information

If the recipient is unable to sign a receipt for service or if the service is rendered by phone, the documentation in the recipient's record should so indicate. The Z code unspecified psychosocial circumstance is covered only for children and adolescents, or adults receiving DHR protective services. For DMH Mental Illness providers, Z04.6 is covered for this service.

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Individual Counseling - (90832-HE, 90834-HE, 90837-HE 90832-HF, 90834-HF, 90837-HF)

Definition

The utilization of professional skills by a qualified practitioner to assist a recipient in a face-to-face (in person or via telemedicine), one-to-one psychotherapeutic encounter in achieving specific objectives of treatment or care for a mental health and/or a substance use disorder. Services are generally directed toward alleviating maladaptive functioning and emotional disturbances relative to a mental health and/or substance use disorder, and restoration of the individual to a level of functioning capable of supporting and sustaining recovery. Individual Counseling may consist of insight oriented, behavior modifying, supportive, or interactive psychotherapeutic services.

Key service functions include the following:

- Interaction where interventions are tailored toward achieving specific goals and/or objectives of the recipient's treatment plan
- On-going assessment of the recipient's presenting condition and progress made in treatment

Eligible Provider Type – DMH Mental Illness/DMH Substance Abuse/DHR

- *Rehabilitative Services Professional (all types)*
- *QSAP II (DMH Substance Abuse only)*

Eligible Provider Type – DYS

- *Rehabilitative Services Professional as defined in 105.1.1*

Billing Unit*:*	1 unit
Maximum Unit:	1 per day, 52 per year
Billing Restrictions:	May not be billed in combination with Partial Hospitalization (H0035), Adult Intensive Day Treatment (H2012), Child & Adolescent Day Treatment (H2012-HA), In-Home Intervention (H2021, H2022-HA), ACT (H0040), PACT (H0040-HQ), Intake (90791-HF), Opioid Use Disorder Treatment (H0020), Outpatient Detoxification – Ambulatory Detoxification With Extended On-Site Monitoring (II-D) (H0013), Outpatient Detoxification – Ambulatory Detoxification Without Extended On-Site Monitoring (I-D) (H0014).

Location

The only excluded settings are hospitals. Services can be delivered in any setting that is convenient for both the recipient and staff member, that affords an adequate therapeutic environment, and that protects the recipient's rights to privacy and confidentiality.

Additional information

The Z code unspecified psychosocial circumstance is covered only for children and adolescents, or adults receiving DHR protective services.

Max Unit = **1 per day**

Billing = 1 of the following codes:

- Code 90832 = therapy given for 16 to 37 minutes
- Code 90834 = therapy given for 38 to 52 minutes
- Code 90837 = therapy given for 53 minutes or greater

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Family Counseling 90846-HE 90846-HF (without patient present)
90847-HE 90847-HF (with patient present)
90849-HE 90849-HF (multiple family group)

Definition

A recipient focused intervention that may include the recipient, his/her collateral* and a qualified practitioner. This service is designed to maximize strengths and to reduce behavior problems and/or functional deficits stemming from the existence of a mental health and/or substance use disorder that interferes with the recipient's personal, familial, vocational, and/or community functioning.
Key service functions include the following:

- Interaction where interventions are tailored toward achieving specific goals and/or objectives of the recipient's treatment plan
- On-going assessment of the recipient's presenting condition and progress being made in treatment

Eligible Provider Type – DMH Mental Illness/DMH Substance Abuse/DHR

Family counseling may be performed by a person who possesses any one or more of the following qualifications:

- Rehabilitative Services Professional (all types)
- QSAP II (DMH Substance Abuse only)

Eligible Staff – DYS

- Rehabilitative Services Provider as defined in 105.1

MI:

Billing Unit:	1 episode=minimum of 60 minutes
Maximum Units:	1 episode per day, 104 per year
Billing Restrictions:	May not be billed in combination with Partial Hospitalization (H0035), Adult Intensive Day Treatment (H2012), Child and Adolescent Day Treatment (H2012-HA), In-Home Intervention (H2021, H2022-HA), ACT (H0040), PACT (H0040-HQ).

SA:

Billing Unit:	1 episode=minimum of 60 minutes (90846-HF/ 90847HF) 1 episode=minimum of 90 minutes (90849-HF)
Maximum Units:	1 episode per day, 104 per year
Billing Restrictions:	May not be billed in combination with Partial Hospitalization (H0035), Intake (90791-HF), Opioid Use Disorder Treatment (H0020), Outpatient Detoxification – Ambulatory Detoxification With Extended On-Site Monitoring

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(II-D) (H0013), Outpatient Detoxification – Ambulatory Detoxification Without Extended On-Site Monitoring (I-D) (H0014).

Location

The only excluded settings are hospitals. Services can be delivered in any setting that is convenient for both the recipient and staff member, that affords an adequate therapeutic environment, and that protects the recipient's rights to privacy and confidentiality.

Additional information

Family therapy is defined as the treatment of family members as a family unit, rather than an individual patient. When family therapy without the patient present (90846) or family therapy with the patient present (90847) is provided, the session is billed as one service (one family unit), regardless of the number of individuals present at the session.

When a family consists of a Medicaid eligible adult and child(ren) and the therapy is *not* directed at one specific child, services may be directed to the adult for effective treatment of the family unit to address the adult's issues and impact on the family. If the adult is *not* eligible and the family therapy is directed to the adult and *not* the child, the service may *not* be billed using the child's recipient id number.

A family is *not* a group and providers may *not* submit a claim for each eligible person attending the same family therapy session.
All members of the family in attendance for the session will sign/mark the signature log or progress note to document their participation in the session (in addition to the therapist documenting their presence/participation).

The Z code unspecified psychosocial circumstance is covered only for children and adolescents, or adults receiving DHR protective services.

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Group Counseling (90853-HE, 90853-HF)

Definition

The utilization of professional skills by a qualified practitioner to assist two or more recipients in a group setting in achieving specific objectives of treatment or care for mental health or substance use disorder. Services are generally directed toward alleviating maladaptive functioning and behavioral, psychological, and/or emotional disturbances, and utilization of the shared experiences of the group's members to assist in restoration of each participant to a level of functioning capable of supporting and sustaining recovery. Group Counseling may consist of insight oriented, behavior modifying, supportive, or interactive psychotherapeutic service strategies. Key service functions include the following:

- Interaction where interventions are tailored toward achieving specific goals and/or objectives of the recipient's treatment plan
- On-going assessment of the recipient's presenting condition and progress being made in treatment

Eligible Provider Type– DMH Mental Illness/DMH Substance Abuse/DHR

Group counseling may be performed by a person who possesses any one or more of the following qualifications:

- Rehabilitative Services Professional (all types)
- QSAP II (DMH Substance Abuse only)

Eligible Provider Type – DYS

- Rehabilitative Services Professional as defined by 105.1.1

MI:

Billing Unit:	1 episode=minimum of 60 minutes
Maximum Units:	1 episode per day, 104 per year
Billing Restrictions:	May not be billed in combination with Partial Hospitalization (H0035), Adult Intensive Day Treatment (H2012), Child & Adolescent Day Treatment (H2012-HA), ACT (H0040), PACT (H0040-HQ).

SA:

Billing Unit:	1 episode=minimum of 90 minutes
Maximum Units:	1 episode per day, 104 per year
Billing Restrictions:	May not be billed in combination with Partial Hospitalization (H0035), Intake (90791-HF), Opioid Use Disorder Treatment (H0020), Outpatient Detoxification – Ambulatory Detoxification With Extended On-Site Monitoring (II-D) (H0013), Outpatient Detoxification –

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Ambulatory Detoxification Without Extended On-Site Monitoring (I-D) (H0014).

Location

The only excluded settings are hospitals. Services can be delivered in any setting that is convenient for both the recipient and staff member, that affords an adequate therapeutic environment, and that protects the recipient's rights to privacy and confidentiality.

Additional information

The Z code unspecified psychosocial circumstance is covered only for children and adolescents, or adults receiving DHR Protective Services.

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Medication Administration 96372-HE 96372-HF (Injectable meds) H0033-HE H0033-HF (oral meds)

Definition

Administration of oral or injectable medications under the direction of a physician, physician assistant, or certified registered nurse practitioner.

Eligible Provider Type– All State Agencies

Medication administration may be performed by a person who possesses any one or more of the following qualifications:

- A registered nurse licensed under Alabama law
- A licensed practical nurse licensed under Alabama law under the direction of a physician
- MAC Worker (Oral Medications Only)

Billing Unit	Episode
Maximum Units	1 per day, 365 per year
Billing Restrictions:	May not be billed in combination with Partial Hospitalization (H0035), ACT (H0040), PACT (H0040-HQ), Opioid Use Disorder Treatment (H0020), Outpatient Detoxification – Ambulatory Detoxification With Extended On-Site Monitoring (II-D) (H0013), Outpatient Detoxification – Ambulatory Detoxification Without Extended On-Site Monitoring (I-D) (H0014), Vivitrol (J2315).

Location

The only excluded settings are hospitals. Services can be delivered in any setting that is convenient for both the recipient and staff member, that affords an adequate therapeutic environment, and that protects the recipient'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. Procedure codes 96372 HE, 96372 HF, H0033 HE, or H0033 HF may be span-billed by multiplying the appropriate number of units for the month by the daily rate. Benefits are limited to 365 units per year. Utilization will be monitored through retrospective reviews. For SA recipients, this service cannot be billed if the MAS nurse has determined they are capable of self-administration.

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Medication Monitoring (H0034-HE)

Definition

Contact between the recipient and a rehabilitative services, or child and adolescent services/adult protective services professional, monitoring compliance with dosage instructions; educating the recipient and/or collateral of expected effects of medications; and/or identifying changes in the medication regimen.

Eligible Provider Type – DMH Mental Illness/DMH Substance Abuse/DHR

Medication monitoring for recipients may be performed by a person who possesses any one or more of the following qualifications:

- Rehabilitative Services Professional (all types)
- Qualified Mental Health Provider – Bachelor's
- QSAP II (DMH Substance Abuse only)
- QSAP III (DMH Substance Abuse only)
- Registered Nurse licensed under Alabama law
- Licensed Practical Nurse licensed under Alabama law
- Pharmacist licensed under Alabama law

Eligible Provider Type – DYS

- Rehabilitative Services Professional as defined in 105.1.1
- Registered Nurse Licensed under Alabama Law
- Licensed Practical Nurse licensed under Alabama law
- Pharmacist licensed under Alabama Law

Billing Unit	15 minutes
Maximum Units	2 per day, 52 per year
Billing Restrictions:	May not be billed in combination with Partial Hospitalization (H0035), In-Home Intervention (H2021, H2022-HA), ACT (H0040), PACT (H0040-HQ), Opioid Use Disorders Treatment (H0020), Outpatient Detoxification – Ambulatory Detoxification With Extended On-Site Monitoring (II-D) (H0013), Outpatient Detoxification – Ambulatory Detoxification Without Extended On-Site Monitoring (I-D) (H0014) , or Vivitrol (J2315).

Location

The only excluded settings are hospitals. Services can be delivered in any setting that is convenient for both the recipient and staff member, that affords an adequate therapeutic environment, and that protects the recipient's rights to privacy and confidentiality.

Additional Information

Medicaid covers this service for mental illness diagnoses only. The code Z 65.9 unspecified psychosocial circumstance is covered only for children and adolescents, or adults receiving DHR protective services.

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Partial Hospitalization Program (H0035-HE, H0035-HF)

Definition
A physically separate and distinct organizational unit that provides intensive, structured, active, clinical treatment, less than 24 hours per day, with the goal of acute symptom remission, immediate hospital avoidance, and/or reduction of inpatient length of stay, or reduction of severe persistent symptoms and impairments that have not responded to treatment in a less intensive level of care.

Key service functions include the following services, which must be available with the program as indicated by individual recipient need:

- Initial screening to evaluate the appropriateness of the recipient's participation in the program
- Development of an individualized program plan
- Individual, group, and family counseling
- Coping skills training closely related to presenting problems (e.g., stress management, symptom management, assertiveness training, and problem solving; as opposed to basic living skills, such as money management, cooking, etc.)
- Medication administration
- Medication monitoring
- Psychoeducational services
- Patient education closely related to the presenting problems, such as diagnosis, symptoms, medication, etc., rather than academic training

Eligible Provider Type – DMH Mental Illness Services/DMH Substance Abuse Services:
MI: The program must have a multi-disciplinary treatment team under the direction of a psychiatrist, certified registered nurse practitioner, or physician's assistant. The program staff are required to follow the current Community Mental Health Program Standards Manual or subsequent revisions.

At a minimum, the treatment team will include a:

- Physician, Physician assistant, OR Licensed Certified Registered Nurse Practitioner (CRNP); and
- Rehabilitative Services Professional; (all types); and
- Licensed practical nurse, and/or
- Qualified Mental Health Provider- Bachelor's OR Qualified Mental Health Provider – Non-Degreed OR Certified Mental Health Adult Peer Specialist

SA: The program must be staffed as specified in current and subsequent revisions of regulations established for this service by the Alabama Department of Mental Health Substance Abuse Services Administrative Code.

- Rehabilitative Services Professional (all types)
- QSAP II
- QSAP III
- Certified Recovery Support Specialist (CRSS)
- QPP
- Licensed Practical Nurse

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Billing Unit:	A minimum of 4 hours
Maximum Units:	1 per day, 130 days per year
Billing Restrictions:	May not be billed in combination with Individual (90832), Family (90846, 90847, 90849), or Group Counseling (90853), Physician Medical Assessment and Treatment (H0004), Medication Administration (96372 HE, 96372 HF, H0033), Medication Monitoring (H0034), Intensive Day Treatment (H2012), Rehabilitative Day Program (H2017), and Outpatient Detoxification – Ambulatory Detoxification With Extended On-Site Monitoring (II-D) (H0013), Outpatient Detoxification – Ambulatory Detoxification Without Extended On-Site Monitoring (I-D) (H0014) and Opioid Use Disorder Treatment (H0020). These restrictions apply while a recipient 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 recipient and staff member, that affords an adequate therapeutic environment and that protects the recipient's rights to privacy and confidentiality.

Additional Information

H0035 may be span-billed by multiplying the appropriate number of units for the month by the daily rate. Benefits are limited to 130 units per year. Utilization will be monitored through retrospective reviews.

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Intensive Family Intervention by a Multi-Person Team (H0037)

Definition

This service is intended to improve family functioning by clinically stabilizing the living arrangement, promoting reunification, or preventing the utilization of out-of-home therapeutic venues (i.e. psychiatric hospital, psychiatric residential treatment facilities, or residential treatment services) for the identified youth. Services are delivered by a multi-person team staffed as defined below and are provided primarily to youth in their living arrangement and within the family system. Services are designed to address both the mental health needs of the youth and the interactions among family members that contribute to an unstable living environment as identified in the Individualized Treatment Plan.

The service array, frequency, and duration must conform to the respective team model and include resource coordination/acquisition to achieve the youth's and their family's goals and aspirations of self-sufficiency, resiliency, permanency, and community integration. At a minimum, the following service types are included:

Individual Counseling

Family Counseling

Psychoeducation

Basic Living

Crisis Intervention (24 hours a day availability)

Medication Monitoring

Mental Health Care Coordination

Treatment Plan Review

Therapeutic Mentoring

Case Management

Eligible Provider Type Multi-Person Team – DYS and DHR

The Intensive Family Intervention team is staffed and functions consistent with the evidence-based criteria of a nationally recognized intensive family intervention model such as Multi-Systemic Therapy (MST), Functional Family Therapy (FFT), or Multi-Dimensional Family Therapy (MDFT). The specific model of Intensive Family Intervention must be approved by the respective state agency. The team must be approved by the respective credentialing oversight body as having the staff, training, operation, and quality assurance measures required by the model.

Billing Unit: One day

Maximum Units: 180 per year

Billing Restrictions: May not be billed in combination with Crisis Intervention (H2011), Individual Counseling (90832, 90834, 90837), Family Counseling ((90846, 90847, 90837), Treatment Plan Review (H0032), Mental Health Care Coordination (H0046), Psychoeducation (H2027), Basic Living Skills (H0036), Medication Monitoring (H0034), Case Management, or

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Therapeutic Mentoring (H2019-N) while a family is enrolled in Intensive Family Intervention

Location

Please note that Intensive Family Intervention, while by definition and practice is usually provided in the child or adolescent consumer's home, infrequently may be provided in a non-traditional setting including educational, child welfare, family court, local parks, or clinic, etc. Such exceptions will not render the service ineligible for billing.

Additional Information:

The eligibility criteria for this service are as follows:

The recipients (DYS ages 12-19th birthday) and DHR 5- through 21st birthday) must have 1. a mental illness diagnosis and related functional impairment which interferes with or limits the child's role or functioning in the family, school, or community and/or a Substance-Related Disorder and 2. the youth and/or family has one or more of the following characteristics:

- insufficient or severely limited resources or skills necessary to cope with the youth's behavioral health crisis
- are involved in or at serious risk of involvement with the juvenile justice system
- have anti-social, aggressive/violent, substance abusing behaviors
- are at risk of out-of-home placement and require intensive, coordinated clinical and supportive intervention
- are returning from out of home placement where the above behaviors received treatment

These services should be billed on a per diem basis while the family is enrolled and receiving this service even though a service may not be provided every day. Span-billing may be utilized by multiplying the appropriate number of units for the month by the daily rate.

Youth participation in group counseling consistent with the Individualized Treatment Plan may be separately billed. Siblings who are each authorized to receive this service must receive individualized services, but family interventions can be provided jointly.

The service documentation must include the way in which the team works with the family and other agencies/support systems to build a clinically oriented transition and discharge plan.

Each included service type must be documented consistent with the requirements for that service type, i.e. individual counseling, family counseling, etc.

The intensive nature of this service should be reflected in the average hours of direct service per family per week.

Treatment Plans must be completed with 30 days of the first face-to-face contact with the youth and family. The Treatment Plan should address the treatment needs identified by a thorough assessment of the youth and family.

Signatures for services are secured on the day the service is delivered.

Utilization will be monitored through the quality assurance measures required by the respective model.

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Adult Mental Illness Intensive Day Treatment (H2012-HE)

Definition

An identifiable and distinct program that provides highly structured services designed to bridge acute treatment and less intensive services, such as Rehabilitative Day Program and Outpatient services, with the goals of community living skills enhancement, increased level of functioning, and enhanced community integration. Intensive Day Treatment shall constitute active, intermediate level treatment that specifically address the recipient's impairments, deficits, and clinical needs.

The following services must be available within the program as indicated by individual recipient need:

- Initial screening to evaluate the appropriateness of the recipient's participation in the program
- Development of an individualized program
- Individual, group, and family counseling
- Coping skills training (e.g., stress management, symptom management, assertiveness training, 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)
- Recipient education closely related to presenting problems, such as diagnosis, symptoms, medication, etc. rather than academic training

Eligible Provider Type– DMH Mental Illness Services

The program staff are required to follow the current Community Mental Health Program Standards Manual or subsequent revisions.

At a minimum, there must be a program coordinator:

- Rehabilitative Services Professional (all types)
- As outlined in Community Mental Health Program Standards Manual, the multi-disciplinary treatment team may also include the following practitioners:
  - Qualified Mental Health Provider – Bachelor's
  - Qualified Mental Health Provider – Non-Degreed
  - Certified Mental Health Peer Specialist - Adult

Billing Unit:	One hour
Maximum Units:	4 per day, 1040 hours per year
Billing Restrictions:	May not be billed in combination with Individual (90832), Family (90846, 90847, 90849), or Group Counseling (90853), Partial Hospitalization Program (H0035), and Rehabilitative Day Program (H2017). These restrictions apply while a recipient is attending/actively enrolled in Intensive Day Treatment whether or not the restricted services occur on the same day as Intensive Day Treatment.

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Location

The only excluded settings are hospitals. Services can be delivered in any setting that is convenient for both the recipient and staff member, that affords an adequate therapeutic environment, and that protects the recipient's rights to privacy and confidentiality.

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Adult Rehabilitative Day Program (H2017 HE)

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 to restore a recipient to productive participation 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 recipients participating in the program.

Key service functions include the following:

1. Initial screening to evaluate the appropriateness of the recipient's participation in the program
2. Development of an individualized treatment plan
    - Psychoeducational services
    - Basic living Skills
    - Coping skills training closely related to presenting problems (e.g., stress management, symptom management, assertiveness training, a problem solving)
    - Utilization of community resources

Eligible Provider Type – DMH Mental Illness

The program staff are required to follow the current Community Mental Health Program Standards Manual or subsequent revisions.

At a minimum, there must be a program coordinator:

- Qualified Mental Health Provider – Bachelor's
- As outlined in Community Mental Health Program Standards Manual, the multi-disciplinary treatment team may also include the following practitioners:
    - Qualified Mental Health Provider – Bachelor's
    - Qualified Mental Health Provider – Non-Degreed
    - Certified Mental Health Peer Specialist - Adult

Billing Unit:	15 minutes
Maximum Units:	16 per day, 4160 per year
Billing Restrictions:	May not be billed in combination with Partial Hospitalization Program (H0035) or Adult Mental Illness Intensive Day Treatment (H2012).

Location

The only excluded settings are hospitals. Services can be delivered in any setting that is convenient for both the recipient and staff member, that affords an adequate therapeutic environment, and that protects the recipient's rights to privacy and confidentiality.

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Child and Adolescent Mental Illness Day Treatment (H2012-HE:HA)

Definition

A combination of goal-oriented rehabilitative services designed to improve the ability of a recipient to function as productively as possible in their 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 recipient's participation in the program
- Development of an individualized treatment plan
- Individual, group, and family counseling
- Psychoeducational Services.
- Basic Living Skills
- Coping skills training closely related to presenting problems (e.g., stress management, assertiveness training, and problem solving)

Eligible Provider Type – DMH Mental Illness, DHR

The program staff are required to follow the current Community Mental Health Program Standards Manual or subsequent revisions.

At a minimum, there must be a program coordinator:

- Rehabilitative Services Professional (all types)

As outlined in Community Mental Health Program Standards Manual, the multi-disciplinary treatment team may also include the following practitioners:

- Qualified Mental Health Provider – Bachelor's
- Qualified Mental Health Provider – Non-Degreed
- Certified Mental Health Peer Specialist - Youth
- Certified Mental Health Peer Specialist - Parent

Billing Unit:	One hour
Maximum Units:	4 per day, 1040 per year
Billing Restrictions:	May not be billed in combination with Individual (90832), Family (90846, 90847, 90849), or Group Counseling (90853). These restrictions apply while a recipient 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 recipient and staff member, that affords an adequate therapeutic environment, and that protects the recipient's rights to privacy and confidentiality.

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Treatment Plan Review (H0032-HE)

Definition

Review and/or revision of a recipient's individualized mental health and/or substance use disorder treatment plan by a qualified practitioner who is not routinely directly involved in providing services to the recipient. This review will evaluate the recipient's progress toward treatment objectives, the appropriateness of services being provided, and the need for a recipient's continued participation in treatment. This service does not include those activities or costs associated with direct interaction between a recipient and his or her primary therapist regarding the recipient's treatment plan. That interaction must be billed through an alternative service, such as individual counseling.

Eligible Provider Type – All State Agencies

Treatment plan review, for mental illness, substance abuse, and child and adolescent services/adult protective services recipients, may be performed by a person who possesses any one or more of the following qualifications:

- Physician
- Physician Assistant
- Certified Registered Nurse Practitioner (CRNP)
- Rehabilitative Services Professional (licensed only)
- Service Supervisor (DHR only)
- Senior Social Work Supervisor (DHR only)

Billing Unit:	15 minutes
Maximum Units:	1 event with up to 2 units every 6 months, 4 per year
Billing Restrictions:	May not be billed in combination with Intake Evaluation (90791), Child and Adolescent In-Home Intervention (H2022-HA), ACT (H0040), and PACT (H0040-HQ).

Deleted: ~~1 event with…DMH SASD providers)~~
Added: 1 event with…4 per year

Location

This service may be provided wherever the recipient's clinical record is stored. This service may be billed while a recipient is in an inpatient setting since it is not a face to face service.

Additional Information

The recipient'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.

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Providers must document this review in the recipient'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 and substance use disorder diagnoses only. The Z code unspecified psychosocial circumstance is covered only for children and adolescents, or adults receiving DHR protective services. The person who completes the treatment plan review for DHR children, adolescents, or adults must meet the criteria in Section 105.2.3.

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Mental Health Care Coordination (H0046-HE) (Previously mental health case consultation)

Definition

Services to assist an identified Medicaid recipient to receive coordinated mental health services from external agencies, providers or independent practitioners.

Key service functions include written or oral interaction in a clinical capacity in order to assist another provider in addressing the specific rehabilitative needs of the recipient, as well as to support continuation of care for the recipient in another setting.

Eligible Provider Type – DMH Mental Illness/DMH Substance Abuse/DHR

- Rehabilitative Services Professional (all types)
- Licensed Registered Nurse
- Licensed Practical Nurse
- Certified Nursing Assistant
- Qualified Mental Health Provider – Bachelor's
- Social Service Caseworker

Eligible Provider Type – DYS

- Rehabilitative Services Professional as defined in 105.1.1
- Licensed Registered Nurse

Eligible Provider Type – DHR / DHR Adult Protective Services

Services may be provided by an individual employed by a public provider department who meets the state merit system qualifications for Social Service Caseworker or above, or an employee of an agency or entity under contract to serve the target population of one of the same public provider agencies who meets an approved equivalency for Social Service Caseworker, or above.

Billing Unit:	*15 minutes*
Maximum Units:	*24 per day, 312 per year*
Billing Restrictions:	*ACT (H0040), PACT (H0040-HQ), In-Home Intervention (H2021, H2022-HA)*

Location

There are no excluded settings. This service may be billed while a recipient 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 Z code unspecified psychosocial circumstance is covered only for children and adolescents, or adults receiving DHR protective services.

Consults may be billed for the staff time spent obtaining prior authorizations and overrides for prescription medications. In addition to the eligible staff listed above LPNs may bill for their time directly related to performing this activity. LPNs **are not** eligible to bill for consults for any other type of activity. Acceptable documentation can be a progress note entered in the recipient's record or the approved authorization/override form filed in the record and dated and signed by the staff member performing the work.

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(Adult) In-Home Intervention (H2021-HE)

Definition

Home based services provided by a treatment team (two-person team) to serve individuals who refuse other outpatient services and/or who need temporary additional support due to increased symptoms or transition from a more intense level of services, to defuse an immediate crisis situation, stabilize the living arrangement, and/or prevent out of home placement of the recipient.

Key service functions include the following when provided by a team composed of a Rehabilitative Services Professional (master's level clinician) and either a Qualified Mental Health Provider – Bachelor's or a Certified Peer Specialist - Adult:

- Individual or family counseling
- Crisis intervention
- Mental Health Care Coordination
- Basic Living Skills
- Psychoeducational Services
- Case Management
- Medication Monitoring
- Peer Services (only when team member is a Certified Mental Health Peer Specialist – Adult)

Key service functions include the following when provided by a team composed of a Registered Nurse and a Qualified Mental Health Provider – Bachelor's or a Certified Mental Health Peer Specialist - Adult:

- Crisis Intervention
- Mental health Care Coordination
- Basic Living Skills
- Psychoeducational Services
- Case Management
- Medication Monitoring
- Medicaid Administration
- Peer Services (only when team member is a Certified Mental Health Peer Specialist – Adult)

Eligible Provider Type – DMH Mental Illness

In-home intervention for mental illness recipients are provided by a two-person team minimally composed of the following:

- A rehabilitative services professional (Master's level) or
- A registered nurse licensed under Alabama law AND EITHER
- A Qualified Mental Health Provider – Bachelor's or
- A Certified Mental Health Peer Specialist - Adult

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All team members must successfully complete an approved case management-training program.

Billing Unit	15 minutes
Maximum Units:	24 per day, 2016 per year
Billing Restrictions: *When team is a Rehab Services Professional AND either a Qualified MH Provider – Bachelor's OR CPS-Adult*	May not be billed in combination with Individual Counseling (90832, 90834, 90837), Family Counseling (90846, 90847, 90849), Mental Health Care Coordination (H0046), Case Management, Psychoeducational Services (H2027), Basic Living Skills (H0036), or Medication Monitoring (H0034). Also, CPS-Adult (H0038-HE) and Therapeutic Mentoring (H2019) when the team member is a Certified Mental Health Peer Specialist – Adult.
Billing Restrictions: *When team is a Registered Nurse AND either a Qualified MH Provider – Bachelor's OR CPS-Adult*	May not be billed in combination with Mental Health Care Coordination (H0046), Case Management, Psychoeducational Services (H2027), Basic Living Skills (H0036), Medication Administration (**96372**), Medication Monitoring (H0034). Also, CPS-Adult (H0038-HE) and Therapeutic Mentoring (H2019) when the team member is a Certified Mental Health Peer Specialist – Adult.

Location

Please note that in-home intervention, while by definition and practice is usually provided in the recipient's home, infrequently may be provided in other locations. Such exceptions will not render the service ineligible for billing as In-Home Intervention.

When the Adult In-Home Intervention team members are together in the same location providing services as a team, H2021 must be billed and unbundled services cannot be billed for that time period. When the team members work independently of each other, each team member must document as to the specific service rendered and bill under the applicable code [i.e. Individual Counseling (90832, 90834, 90837), Mental Health Care Coordination (H0046), etc.] and the billing restrictions will not apply. Travel time to and from the service location must be excluded from the billing.

Utilization will be monitored through retrospective reviews.

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Child and Adolescent In-Home Intervention (H2022-HE:HA)

Definition

Structured, consistent, strength-based therapeutic intervention provided by a team for a child or youth with a serious emotional disturbance (SED) and his or her family for the purpose of treating the child's or youth's behavioral health needs. In-Home Intervention also addresses the family's ability to provide effective support for the child or youth, and enhances the family's capacity to improve the child's or youth's functioning in the home and community. Services are directed towards the identified youth and his or her behavioral health needs and goals as identified in the treatment plan or positive-behavior support plan are developed by a qualified behavioral clinician where appropriate. Services include therapeutic and rehabilitative interventions, including counseling and crisis intervention services, with the individual and family to correct or ameliorate symptoms of mental health conditions and to reduce the likelihood of the need for more intensive or restrictive services.

These services are delivered in the family's home or other community setting and promote a family-based focus in order to evaluate the nature of the difficulties, defuse behavioral health crises, intervene to reduce the likelihood of a recurrence, ensure linkage to needed community services and resources, and improve the individual child's/adolescent's ability to self-recognize and self-managed behavioral health issues, as well as the parents' or responsible caregivers' skills to care for their child's or youth's mental health conditions. The In-Home Intervention team provides crisis services to children and youth served by the team.

Key service functions include the following:

- Psychosocial Assessment/Intake – If not previously assessed with completion of a Psychosocial Assessment/Intake, the IHI team can perform the Psychosocial Assessment/Intake as part of the bundled service delivery.
- Individual Counseling
- Family Counseling
- Psychoeducation
- Basic Living Skills
- Crisis intervention (24 hour availability)
- Medication Monitoring
- Mental Health Care Coordination
- Treatment Plan Review

Eligible Provider Type – DMH Mental Illness

In-home intervention for mental illness recipients may be provided by a two-person team minimally composed of the following:

- A rehabilitative services professional staff (all types)
- AND either
- A Qualified Mental Health Provider – Bachelor's

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OR

- Certified Mental Health Peer Specialist - Parent

All team members must successfully complete an approved Child and Adolescent In-Home Intervention training program.

Billing Unit:	One day (children)
Maximum Units:	140 per year
Billing Restrictions:	May not be billed in combination with Crisis Intervention (H2011), Individual Counseling (90832, 90834, 90837), Family Counseling (90846, 90847, 90849), Treatment Plan Review (H0032), Mental Health Care Coordination (H0046), Psychoeducation (H2027), Basic Living Skills (H0036), Medication Monitoring (H0034), or Therapeutic Mentoring (H2019-HN) while a family is enrolled in In-Home intervention.

Location

This cannot be provided in an Inpatient hospital setting or Inpatient Psychiatric Residential Treatment Facility. Please note that In-Home intervention, while by definition and practice is usually provided in the child or adolescent consumer's home, infrequently may be provided in non-traditional settings including educational, child-welfare, family court, local parks, or clinic, etc. Such exceptions will not render the service ineligible for billing.

Additional Information

- Medicaid covers this service for mental illness diagnoses only.
- Only persons who meet the definition for Serious Emotional Disturbance (SED) and meet the criteria are eligible for this service.
- The team will primarily be together during the provision of services to children and their families, but some of the services have to be provided separately.
- These services should be billed on a per diem basis while the family is enrolled and receiving in-home intervention services even though a service might not be provided every day.
- Span-billing may be utilized by multiplying the appropriate number of units for the month by the daily rate.
- Covered for children and adolescents only (age 5 to 18 years of age).
- Covered for transitional age young adults (age 18 to 26 years of age).
- The active caseload for a team will not exceed six (6) families.
- In-home must be available other than 8:00 A.M. to 5:00 P.M.

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- The intensive nature of this service should be reflected in the average hours of direct service per family per week.

- In-Home Intervention should follow service delivery patterns taught in the DMH approved In-Home Training Program to maintain the consistency and fidelity of the model.

- Treatment Plan must be completed within 30 days of the first therapeutic contact with the consumer. The Treatment Plan should address the treatment needs identified by the DMH approved assessment tool.

- In-Home Intervention Services are discontinued and enrollees are referred to other services when the team is no longer a two-person team. Examples would include the loss of one of the team members, extended illness, maternity leave, etc. exceeding a two week period.

- Utilization will be monitored through retrospective reviews.

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Mental Health and Substance Use Disorders Assessment Update (H0031:HF)

HF = Substance Abuse

Definition

A structured interview process that functions to evaluate a recipient's present level of functioning and/or presenting needs. The assessment is used to establish additional or modify existing diagnoses, establish new or additional rehabilitation service goals, assess progress toward goals, and/or to determine the need for continued care, transfer, or discharge. The use of the ADMH Update Assessment tool is a required element.

Eligible Provider Type DMH Mental Illness/DMH Substance Abuse/DHR

- Rehabilitative Services Professional (all types)

Eligible Provider Type – DYS

- Rehabilitative Services Professional as defined in 105.1.1

Billing Unit:	15 minutes
Maximum Units:	8 units per day, 56 units per year
Billing Restrictions:	May not be billed in combination with Intake Evaluation (90791)

Location

The only excluded settings are hospitals. Services can be delivered in any setting that is convenient for both the recipient and staff member, that affords an adequate therapeutic environment and that protects the recipient's rights to privacy and confidentiality.

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Behavioral Health Placement Assessment (H0002-HE) (formerly Pre-Hospitalization Screening)

Definition

A structured interview process conducted by a qualified professional for the purpose of identifying a recipient's presenting strengths and needs and establishing a corresponding recommendation for placement in an appropriate level of care. This process may incorporate determination of 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 recipient's need for local or state psychiatric hospitalization
- An assessment of whether the recipient 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 Provider Type – DMH Mental Illness, DHR/ DHR Adult Protective Services

Behavioral Health Placement Assessment may be performed by a person who possesses any one or more of the following qualifications:

- Rehabilitative Services Professional (all types)
- Licensed registered nurse

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 recipient and staff member, that affords an adequate therapeutic environment, and that protects the recipient's rights to privacy and confidentiality.

Additional Information

- Providers may bill for time spent in court testimony while a recipient is in an inpatient unit.
- For DMH Mental Illness providers, Z04.6 is covered for this service.
- For DMH Mental Illness providers, this service also covers children/adolescents assessments for appropriate level of care and/or appropriate community-based services to divert from out of home placement.

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Basic Living Skills (H0036-HE – Individual; H0036-HE:HQ – Group)

Definition

Psychosocial services provided to an individual or group to restore skills that enable a recipient to establish and improve community tenure and to increase his or her capacity for age-appropriate independent living. This service also includes training about the nature of illness, symptoms, and the recipient's role in management of the illness.

Key services functions include the following:

- Training and assistance in restoring skills such as personal hygiene, housekeeping, meal preparation, shopping, laundry, money management, using public transportation, medication management, healthy lifestyle, stress management, and behavior education appropriate to the age and setting of the recipient
- Patient education about the nature of the illness, symptoms, and the recipient's role in management of the illness

Eligible Provider Type– DMH Mental Illness/DMH Substance Abuse/DHR

Basic living skills may be provided by an individual **SUPERVISED** by a staff member who meets at least one of the following qualifications:

- Rehabilitative Services Professional (all types),
- Licensed Registered nurse,
- Social Service Caseworker (DHR only),

Eligible Provider Type – DYS

Basic living skill may be provided by an individual with at least a high school diploma or GED who is supervised by a staff member who meets at least one of the following qualifications:

- Rehabilitative Services Professional as defined in 105.1.1
- Licensed Registered Nurse

Eligible Provider Type – DHR / DHR Adult Protective Services

Services may be provided by an individual employed by a public provider department who meets the state merit system qualifications for Social Service Caseworker or above, or an employee of an agency or entity under contract to serve the target population of one of the same public provider agencies who meets an approved equivalency for Social Service Caseworker, or above.

Billing Unit:	15 minutes
Maximum Units:	2080 units per year
	20 per day (individual)
	8 per day (group)
Billing Restrictions:	May not be billed in combination with In-Home Intervention (H2021,H2022-HA), ACT (H0040), PACT (H0040-HQ), Opioid Use Disorder Treatment (H0020), Outpatient Detoxification –

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Ambulatory Detoxification With Extended On-Site Monitoring (II-D) (H0013), Outpatient Detoxification – Ambulatory Detoxification Without Extended On-Site Monitoring (I-D) (H0014) and H0035-HF Partial Hospitalization.

Location

The only excluded settings are hospitals. Services can be delivered in any setting that is convenient for both the recipient and staff member, that affords an adequate therapeutic environment, and that protects the recipient's rights to privacy and confidentiality.

Additional Information:

Individual Basic Living Skills means the skill can only be taught to one recipient at a time per staff member. Group Basic Living Skills is a skill that is being taught to two or more recipients during the same period of time.

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Psychoeducational Services (H2027-HE – Individual; H2027-HE:HQ – Group) (formerly Family Support and Education)

Definition

Structured, topic specific educational services provided to assist the recipient and the families* of recipients in understanding the nature of the identified behavioral health disorder, symptoms, management of the disorder, how to help the recipient be supported in the community and to identify strategies to support restoration of the recipient to his/her best possible level of functioning.

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
- Ways in which the family member can support the recipient

Eligible Provider Type– DMH Mental Illness/DHR

Psychoeducational services may be provided by an individual **SUPERVISED** by a staff member who meets at least one of the following qualifications:

- Rehabilitative Services Professional (all types),
- Social Service Caseworker (DHR only),
- Licensed Registered Nurse

Eligible Provider Type – DMH-Substance Abuse

Services may be provided by an individual who meets one of the following eligible provider types:

- Rehabilitative Services Professional I (all types)
- QSAP II
- QSAP III
- CRSS

Eligible Provider Type – DYS

Psychoeducational services may be provided by an individual with at least a high school diploma or GED who is supervised by a staff member who meets at least one of the following qualification:

- Rehabilitative Services Professional as defined in 105.1.1
- Licensed Registered Nurse

Eligible Provider Type – DHR / DHR Adult Protective Services

Services may be provided by an individual employed by a public provider department who meets the state merit system qualifications for Social Service

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Caseworker or above, or an employee of an agency or entity under contract to serve the target population of one of the same public provider agencies who meets an approved equivalency for Social Service Caseworker, or above.

Billing Unit:	15 minutes
Maximum Units:	416 units per year *8 per day for services provided to an individual recipient's family* *8 per day for services provided to a group of recipients' families*
Billing Restrictions:	May not be billed in combination with In-Home Intervention (H2021, H2022-HA) ACT (H0040), PACT (H0040-HQ), Opioid Use Disorder Treatment (H0020), Outpatient Detoxification – Ambulatory Detoxification With Extended On-Site Monitoring (II-D) (H0013), Outpatient Detoxification – Ambulatory Detoxification Without Extended On-Site Monitoring (I-D) (H0014) and H0035-HF Partial Hospitalization.

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 recipient's rights to privacy and confidentiality.

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Assertive Community Treatment (ACT) (H0040-HE) (H0040-HE:HA)
Program for Assertive Community Treatment (PACT) (H0040-HE:HQ)

Definition

Treatment services provided primarily in a non-treatment setting by a member of an ACT or PACT team, staffed pursuant to ADMH regulations promulgated in the Alabama Administrative Code for adult recipients with serious mental illness or co-occurring substance use and mental health disorders who are in a high-risk period due to an exacerbation of the behavioral health disorder and/or returning from an episode of inpatient/residential psychiatric care, or who are consistently resistant to traditional clinic-based treatment interventions and are difficult to engage in an ongoing treatment program.

Key service functions include, but are not limited to, the following:

- Intake
- Medical assessment and treatment
- Medication administration
- Medication monitoring
- Individual, group, and/or family counseling
- Crisis intervention
- Mental health care coordination
- Case management
- Psychoeducational Services
- Basic living skills

The only services that may be billed in addition to ACT or PACT are Partial Hospitalization (H0035), Intensive Day Treatment (H2012), and Rehabilitative Day Program (H2017).

Eligible Provider Type– DMH Mental Illness

The program must be staffed by an assigned team with a minimum of three FTE staff. The program staff are required to follow the current Community Mental Health Program Standards Manual or subsequent revisions.

Of the three FTE staff, it is required to have a least:

- *1 full-time Rehabilitative Services Professional (master's level clinician)*
- *1 full-time Qualified Mental Health Provider – Bachelor's, and*
- *.50 FTE of either an RN or LPN.*

There must be an assigned (ACT or PACT) team that is identifiable by job title, job description, and job function. The team must be staffed in accordance with DMH certification standards. Each member of the team must be known to the recipient and must individually provide services to each recipient 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 recipient ratio on an ACT team where the part-time psychiatrist is not counted as one staff member or a 1:10 staff to recipient ratio on a PACT team.

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Billing Unit:	One day
Maximum Units:	365 days per year
Billing Restrictions:	May not be billed in combination with Intake Evaluation (90791), Medical Assessment and Treatment (H0004), Medication Administration (96372-HE), Medication Monitoring (H0034), Basic Living Skills (H0036), Psychoeducation (H2027), Individual (90804-HE), Family (90846-HE, 90847-HE, 90849-HE), Group Counseling (90853-HE), Crisis Intervention (H2011), Mental Health Care Coordination (H0046) , or Treatment Plan Review (H0032) .

Location

The only excluded settings are nursing homes. ACT and PACT services may be billed on a daily basis even though the recipient might not be seen or contacted by the team each day. ACT and PACT services may be billed while a recipient is hospitalized briefly for stabilization or medical treatment. Services can be delivered in any setting that is convenient for both the family and staff member, that affords an adequate service environment, and that protects the recipient's rights to privacy and confidentiality.

Additional Information

- Documentation of the required staffing and all recipient contacts by ACT and PACT team members shall be included in the recipient's medical record. All service documentation shall follow the guidelines in Section 105.2.3.
- Recipient signatures are not required for ACT and PACT key service functions; however, services which are provided outside the ACT and PACT benefit will require recipient signatures.
- H0040 HE, H0040 HE:HA, and H0040-HE:HQ may be span-billed by multiplying the appropriate number of units for the month by the daily rate. Benefits are limited to 365 units per calendar year.
- H0040, H0040 HE:HA, and H0040 HE:HQ services delivered by the psychiatrist or physician extender (CRNP and PA) can be delivered both face to face and their telemedicine (virtual).
- Utilization will be monitored through retrospective reviews.

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Opioid Use Disorder Treatment (H0020: HF - Methadone, H0020: HF:AM – Buprenorphine, J2315:HF - Vivitrol)

Definition

The administration of medication, including the use of FDA approved medications for the use of opioid use disorders, to recipients who have a diagnosed opioid use disorder. Medication is administered to support the recipient's efforts to restore adequate functioning in major life areas that have been debilitated as a result of opioid addiction. This service includes medication administration and concurrent related medical and clinical services.

Eligible Provider Type – DMH Substance Abuse

The program must be staffed as specified in current and subsequent revisions of:

(1) State regulations established for this service by the Alabama Department of Mental Health and published in the Alabama Administrative Code; and

(2) Federal regulations established for this service by the Substance Abuse and Mental Health Services Administration

Eligible Provider Type for Administration of Medication:

- Physician
- Physician's Assistant
- CRNP
- RN
- LPN

Billing Unit:	One day
Maximum Units:	365 per year for H0020. 1 per month for J2315

Location

Services can be delivered in any setting that is acceptable for both the recipient and staff member, that affords an adequate therapeutic environment, and that protects the recipient's rights to privacy and confidentiality. Location should be in compliance with all applicable federal, state, and local codes.

Additional Information

H0020 may be span-billed by multiplying the appropriate number of units for the month by the daily rate. Benefits are limited to 365 units per year. Please utilize the AM modifier when billing for Buprenorphine. Utilization will be monitored through retrospective reviews.

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Outpatient Detoxification (H0013: HF – Ambulatory Detoxification With Extended On-Site Monitoring [II-D], H0014: HF – Ambulatory Detoxification Without Extended On-Site Monitoring [I-D])

Definition

Interactions with a recipient for the purpose of medically managing mild to moderate withdrawal symptoms from alcohol and/or other drugs in an ambulatory setting. Services are provided in regularly scheduled sessions under a defined set of policies, procedures, and medical protocols by authorized medical personnel.

Eligible Provider Type – DMH Substance Abuse

The program must be staffed as specified in current and subsequent revisions of regulations established for this service by the Alabama Department of Mental Health Substance Abuse Services Administrative Code.

Eligible Provider Type:

- Rehabilitative Services Professional (all types)
- QSAP II
- QSAP III
- Certified Recovery Support Specialist (CRSS)
- QPP, with specialized training
- Licensed Registered Nurse
- Licensed Practical Nurse

Billing Unit: 1 day;

Maximum Units: 365 days per year

Billing Restrictions: Opioid Use Disorder Treatment (H0020), Partial Hospitalization (H0035)

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Peer Support Services (Youth: H0038-HE:HA- or HE:HA:HQ (Group), Adult: H0038 HE or HE:HQ (Group) or- HF or HF:HQ (Group), Parent; HE:HS or HE:HS:HQ (Group)

Definition

Peer Support Service (Adult/Child and Adolescent/Family/Recovery Support Specialist) – Peer Support services provides structured, scheduled activities that promote socialization, recovery, self-advocacy, development of natural supports, and maintenance of community living skills, by Certified Peer Specialists (Adult, Youth, Family Peer Specialists, Recovery Support Specialist). Peer Support service actively engages and empowers an individual and his/her identified supports in leading and directing the design of the service plan and thereby ensures that the plan reflects the needs and preferences of the individual (and family when appropriate) with the goal of active participation in this process. Additionally, this service provides support and coaching interventions to individuals (and family when appropriate) to promote recovery, resiliency and healthy lifestyles and to reduce identifiable behavioral health and physical health risks and increase healthy behaviors intended to prevent the onset of disease or lessen the impact of existing chronic health conditions. Peer supports provide effective techniques that focus on the individual's self-management and decision making about healthy choices, which ultimately extend the members' lifespan. Family peer specialists assist children, youth, and families to participate in the wraparound planning process, access services, and navigate complicated adult/child-serving agencies.

Eligible Provider Type – DMH Mental Illness, DMH Substance Abuse, DHR

MI: Certified Mental Health Peer Specialist – Youth

Certified Mental Health Peer Specialist – Adult

Certified Mental Health Peer Specialist – Parent

DMH – SA: Certified Recovery Support Specialist (CRSS)

Certified Mental Health Peer Specialists (DMH-MI) – Youth, Adult, Parent and Certified Recovery Support Specialists (DMH-SA) must successfully complete an approved AMA Peer training program authorized by the appropriate state agency department within six (6) months of date of hire.

Billing Unit:	15 minutes
Maximum Units:	Limited to 20 units per day (individual) and 8 units per day (group). 2,080 units per year for group services and 2,080 units per year for individual services.
Billing Restrictions:	Certified Peer Services – Youth may not be billed in combination with Therapeutic Mentoring (H2019), and Certified Peer Services – Adult (H0038 HE)

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Certified Peer Services – Adult may not be billed in combination with Therapeutic Mentoring (H2019), Certified Peer Services – Youth (H0038 HE:HA), and Adult In-Home Intervention (H2021) if one of the team members is a Certified Peer Specialist-Adult.

Certified Peer Services – Parent cannot be billed in combination with C&A In-Home Intervention (H2022-HA) if one of the team members is a Certified Peer Specialist – Parent.

Location

Services can be delivered in any setting that is convenient for both the recipient and staff member, that affords an adequate therapeutic environment, and that protects the recipient's rights to privacy and confidentiality, to include inpatient hospitals and inpatient psychiatric residential facilities

Additional Information

MI Youth Peer Services and/or MI Parent Peer Services can be billed during a Child and Family Care Team meeting the Target 10 SED care plan is being developed or reviewed, if they are providing peer service that is documented on the treatment plan.

Peer Services should follow service delivery patterns taught in the DMH approved Certified Peer Specialist training to maintain the consistency and fidelity of the model.

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Psychosocial Rehabilitation Services – Working Environment (H2025-HE, H2025-HF)

Definition

Psychosocial services that provide rehabilitative supports with the goal of restoring skills needed to be prepared for community-living activities that may result in employability, promote recovery/wellness, prevent the escalation of a mental health condition into a crisis situation or into a chronic/significantly disabling disorder, improve community-based functioning, alleviate symptoms, and decreasing isolation. The goal of the service is to help recipients be prepared for community-living/activities that may ultimately result in employability. This service does not include educational, vocational or job training services.

Eligible Staff:

DMH Mental Illness and Substance Abuse:

The program must be staffed as specified in current and subsequent revisions of regulations established for this service by the Alabama Department of Mental Health Substance Abuse Services Administrative Code.

- Rehabilitative Services Professional (all types)
- Qualified Mental Health Provider – Bachelor's
- Qualified Mental Health Provider – Non-Degreed
- Certified Mental Health Peer Specialist - Adult
- Certified Mental Health Peer Specialist - Youth
- QSAP II
- QSAP III
- QPP (Qualified Paraprofessionals)

Billing Unit:	15 minutes
Maximum Units:	32 units per day, 320 units per month
Billing Restrictions:	None

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Screening (H0049-HF)

Definition

An encounter in which a brief, valid, questionnaire is administered by trained personnel to examine the context, frequency, and amount of alcohol or other drugs used by a recipient. This process seeks to identify recipients who have an alcohol or drug use disorder or are at risk for development of such. The service includes feedback on the screening results, and recommendations and referral for additional services, if indicated. This is a covered service for recipients whose use of alcohol and/or drugs has adversely impacted functioning in a major life area.

Eligible Staff – DMH Substance Abuse

- Rehabilitative Services Professional (all types)
- QSAP II
- QSAP III
- QPP, with specialized training
- CRSS

Billing Unit: Episode

Maximum Units: 2 units per year

Billing Restriction: Must be billed either in conjunction with 90791, H0050, or billed with no additional services. Screening should result in an assessment, brief intervention, or no additional services.

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Brief Intervention (H0050-HF)

Definition

A brief motivational encounter conducted after a recipient has completed an approved alcohol and drug screening procedure in which a potential alcohol or drug use problem was identified. During this brief encounter, a trained clinician provides feedback on the recipient's alcohol and/or drug use patterns, expresses concerns about the pattern of use as clinically indicated, provides advice in regard to strategies to eliminate or cut back in regard to destructive alcohol/drug use patterns, assists in development of an action plan, and initiates referrals as appropriate (these individuals should not already have an established SUD diagnosis).

Eligible Provider Type – DMH Substance Abuse

- Rehabilitative Services Professional (all types)
- QSAP II
- QSAP III
- QPP, with specialized training

Billing Unit: 15 minutes

Maximum Units: 8 units per year

Billing Restriction: Must be billed either in combination with H0050

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Nursing Assessment and Care (T1001-HE-U1, T1001-HE-U2, T1001-HF-U1, T1001-HF-U2, T1002-HE-U1, T1002-HF-U1, T1003-HE-U2, T1003-HF-U2)

Definition

Nursing Assessment and Care services are face-to-face (in person or via telemedicine/telehealth) contacts with an individual to monitor, evaluate, assess, establish nursing goals, and/or carry out physicians' orders regarding treatment and rehabilitation of the physical and/or behavioral health conditions of an individual as specified in the individualized recovery plan. It includes providing special nursing assessments to observe, monitor and care for physical, nutritional and psychological issues or crises manifested in the course of the individual's treatment; to assess and monitor individual's response to medication to determine the need to continue medication and/or for a physician referral for a medication review; assessing and monitoring an individual's medical and other health issues that are either directly related to the mental health or substance related disorder, or to the treatment of the disorder (e.g. diabetes, cardiac and/or blood pressure issues, substance withdrawal symptoms, weight gain and fluid retention, seizures, etc.); venipuncture required to monitor and assess mental health, substance disorders or directly related conditions, and to monitor side effects of psychotropic medication; consultation with the individual's family and/or significant others for the benefit of the client about medical and nutritional issues; to determine biological, psychological, and social factors which impact the individual's physical health and to subsequently promote wellness and healthy behavior and provide medication education and medication self-administration training to the individual and family.

Eligible Provider Type – DMH Mental Illness, DMH Substance Abuse/DYS

- Licensed Registered Nurse
- Licensed Practical Nurse

Billing Unit:	15 minutes
Maximum Units:	2 units per day in a specialized level of care; 732 units per year
Billing Restrictions:	MI: None SA: May not be billed in combination with Medical Assessment and Treatment (H0004-HF), Opioid Use Disorder Treatment (H0020), Outpatient Detoxification – Ambulatory Detoxification With Extended On-Site Monitoring (II-D) (H0013), Outpatient Detoxification – Ambulatory Detoxification Without Extended On-Site Monitoring (I-D) (H0014)

Location

- The only excluded settings are nursing homes and hospitals.

Services can be delivered in any community settings that are convenient for both the recipient and staff member, that affords an adequate therapeutic

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environment and that protects the recipient's rights to privacy and confidentiality.

Additional information

- T1001 - Nursing Assessment and Care
- T1002 - RN Services
- T1003 – LPN Services

Modifiers

- U1 = RN
- U2 = LPN

T1001 – Nursing Assessment and Care-

- To monitor, evaluate, assess, and establish nursing goals;
- To provide special nursing assessment to observe, monitor and care for physical, nutritional, and psychological issues or crisis manifested; in the course of the individual's treatment;
- To assess and monitor response to medication to determine the need to continue medication and/or for a physician referral for a medication review;
- To assess and monitor medical and other health issues that are directly related to the mental health or substance related disorder, or to the treatment of the disorder (e.g., diabetes, cardiac and/or blood pressure issues, substance withdrawal symptoms, weight gain and fluid retention, seizures)

T1002 – RN Services-

- Carry out physicians' orders regarding treatment and rehabilitation of the physical and/or behavioral health conditions of an individual as specified in the individualized treatment plan:
- Venipuncture required to monitor and assess mental health, substance disorders or directly related conditions, and to monitor side effects of psychotropic medication.
- Consultation with the individual's family and/or significant others for the benefit of the recipient about medical and nutritional issues.
- Determining biological, psychological, and social factors which impact the recipient's physical health and to subsequently promote wellness and health behavior;
- Providing medication education and medication self-administration training to the recipient and family.

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T1003 – LPN Services

- Carry out physicians' orders regarding treatment and rehabilitation of the physical and/or behavioral health conditions of an individual as specified in the individualized treatment plan;
- Venipuncture required to monitor and assess mental health, substance disorders or directly related conditions, and to monitor side effects of psychotropic medication.
- Consultation with the individual's family and/or significant others for the benefit of the recipient about medical and nutritional issues.
- Determining biological, psychological, and social factors which impact the recipient's physical health and to subsequently promote wellness and health behavior;
- Providing medication education and medication self-administration training to the recipient and family.

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Therapeutic Mentoring (H2019-HE:HA, H2019-HE:HA:HQ)

Definition

Therapeutic Mentoring Services provide a structured one on one intervention to a child or youth and their families that is designed to ameliorate behavioral health-related conditions that prevent age-appropriate social functioning. This service includes supporting and preparing the child or youth in age-appropriate behaviors by restoring daily living, social and communication skills that have been adversely impacted by a behavioral health condition. These services must be delivered according to an individualized treatment plan and progress towards meeting the identified goals must be monitored and communicated regularly to the clinician so that the treatment plan can be modified as necessary. Therapeutic mentoring may take place in a variety of settings including the home, school or other community settings. The therapeutic mentor does not provide social, educational, recreational or vocational services.

Component Services include:

- Basic Living Skills
- Social Skills Training
- Coping Skills Training
- Assessment
- Plan Review
- Progress Reporting
- Transition Planning

Eligible Provider Type – All State Agencies

- Rehabilitative Services Professional (all types)
- Social Service Caseworker
- Licensed Registered Nurse
- Licensed Practical Nurse
- Qualified Mental Health Provider – Bachelor's Or,
- Qualified Mental Health Provider – Non-Degreed

Therapeutic Mentors must successfully complete an approved AMA Therapeutic Mentor training program authorized by the appropriate participating state agency within six (6) months of date of hire.

Billing Unit:	15 minutes
	8 units (unit = 15 minutes) per day, individual
	8 units (unit = 15 minutes) per day, group
Maximum Units:	416 per year (416 units per year for individual and 416 units per year for group)

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Billing Restrictions: May not be billed in combination with C&A In-Home Intervention (H2022-HA), Certified Youth Peer Services (H0038 HE:HA or HE:HA:HQ, or Certified Adult Peer Services (H0038 HE:HB or HE:HB:HQ)

Location

The only excluded settings are hospitals and inpatient psychiatric residential facilities. Services can be delivered in any community settings that ate convenient for both the recipient and staff member, that affords an adequate therapeutic environment, and that protects the recipient's rights to privacy and confidentiality.

Additional Information

Therapeutic Mentoring should follow service delivery patterns taught in the DMH approved Therapeutic Mentoring training to maintain the consistency and fidelity of the model.

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.

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105.2.3 Requirements for Recipient Intake, Treatment Planning, and Service Documentation

An intake evaluation must be performed for each recipient 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 recipient'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 recipient is experiencing

Providers use the standardized substance abuse psychosocial assessment as the intake instrument for substance abuse recipients.

Eligible Provider Type -- DMH Mental Illness

A written treatment plan (service plan, individualized family service plan, plan of care, etc.) must be completed by the fifth outpatient service, within ten working days after admission in all day programs or residential program, or within other time limits that may be specified under programs specific requirements.

The treatment plan must include the following:

- Represents a person-centered, recovery-oriented treatment planning process through which consumers are assisted to articulate their vision and hope for how their lives will be changed for the better within three to five years (long term recovery vision), to identify short-term outcomes that will assist in achieving the recovery goal (treatment goals), and to specify services and supports including referrals to outside agencies necessary to overcome barriers to achieving the outcomes (necessary services and supports)
- Identifies needed safety interventions based on history of harm to self or others
- Uses a strengths-based approach to treatment planning by identifying consumer and environmental positive attributes that can be used to support achievement of goals and objectives
- Identifies psychiatric, psychological, environmental, and skills deficits that are barriers to achieving desired outcomes

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- Identifies treatment and supports that are needed to address barriers to achieving desired therapeutic goal

Eligible Provider Type – DMH Substance Abuse/DHR/DYS/DHR Adult Protective Services

A written treatment plan (service plan, individualized family service plan, plan of care, etc.

Must be completed by the fifth outpatient services, within ten working days after admission in all day programs or residential program, or within other time limits that may be specified under programs specific requirements. For SA services, the patient, counselor, and licensed staff as noted above must all approve the treatment plan prior to the provision of SA treatment services.

- Identification of the clinical issues that will be the focus of treatment
- Specific services necessary to meet the recipient's needs
- Referrals as appropriate for needed services not provided directly by the agency
- Identification of expected outcomes toward which the recipient and therapist will be working to impact upon the specific clinical issues

  Unless clinically contraindicated, the recipient will sign/mark the treatment plan to document the consumer's/recipient's participation in developing and/or revising the plan. If the recipient is under the age of 14 or adjudicated incompetent, the parent/foster parent/legal guardian must sign the treatment plan.

Eligible Provider Type - All State Agencies:

The treatment plan must be approved in writing by any one of the following:

- Physician
- Physician Assistant
- Certified Registered Nurse Practitioner (CRNP)
- Rehabilitative Services Professional (licensed only)

Eligible Provider Type – DHR/DHR Adult Protective Services

- Service Supervisor
- Senior Social Work Supervisor

For SA services, the patient, counselor, and licensed staff as noted above must all approve the treatment plan prior to the provision of SA treatment services.

Services may be provided and billed between the initial intake service and the development of the treatment plan if provided within the allowed timeframe for treatment plan development. Once the treatment plan is developed, 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 care coordination, behavioral health placement assessment, mental health and substance use disorders assessment update, and

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treatment plan review. Changes in the treatment plan must be approved as described above.

The preferred course of treatment for persons with co-occurring disorders (MI/SA) is integrated services where both mental illness and substance abuse clinical issues are addressed in the same treatment setting, whether that setting primarily provides mental illness or substance abuse treatment. In cases where integrated services are not possible, a co-occurring recipient may receive mental illness and substance abuse services simultaneously from one or more certified providers. In cases where mental illness and substance abuse services are provided independently, the daily caps specific to each service are cumulative for the day and are not interactive.

In all cases, the diagnosis and treatment plan should reflect both disorders and the interventions needed for both.

After completion of the initial treatment plan, staff must review the recipient's treatment plan once every three months to determine the recipient's progress toward treatment objectives, the appropriateness of the services furnished, and the need for continued treatment. Providers must document this review in the recipient'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. For DMH MI and SA services, the treatment plan review must be completed and signed by the appropriate staff in the required time frame in order to continue billing for services

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 recipient's record for each session, service, or activity for which Medicaid reimbursement is requested must comply with any applicable certification or licensure standards and must include the following, at a minimum:

- The identification of the specific services rendered
- The date and the amount of time that the services were rendered (to include the time started and the time ended)
    - For Mental Health Care Coordination, Diagnostic Testing, Behavioral Health Placement Assessment, Basic Living Skills, and Crisis Intervention which can be provided in multiple, non-continuous times during the same day, it is permissible to aggregate the billable hours that are delivered at different times during the day and to write one note that covers all the different times showing one beginning and ending time covering the time span from start to finish with that consumer and service for that day.
    - Partial Hospitalization (for DMH MI providers only), Adult Intensive Day Treatment, Rehabilitative Day Program, Child and Adolescent Day Treatment, Assertive Community Treatment, Program for Assertive Community Treatment, and In-Home Intervention which are billed either hourly up to a daily maximum or per diem will show the time the service is started for the day and ended for the day.

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- 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 recipient's progress, or lack thereof, related to each of the identified clinical issues discussed

All entries must be legible and complete, and must be signed and dated by the person (identified by name and discipline) who is responsible for ordering, providing, or evaluating the service furnished. The author of each entry must be identified and must sign his or her entry.

Documentation of Medicaid recipients' signatures may be entered on a sign-in log, service receipt, or any other record that can be used to indicate the recipient's signature and the date of service. The recipient's signature is only required one time per day that services are provided (for DMH MI, DHR, and DYS providers only). Treatment plan review, mental health care coordination, behavioral health placement assessment, crisis intervention, psychoeducational services, ACT, PACT, C&A In-Home Intervention, and any non-face-to-face services that can be provided by telephone do not require recipient signatures.

ACT and PACT services are billed as a bundled service on a daily rate even though the recipient might not be seen or contacted by the team each day. Documentation of the required staffing and any service provided to or on behalf of a recipient must be included in the recipient's medical record.

When clinical records are audited, Medicaid will apply the list of required documentation to justify payment. Documentation failing to meet the minimum standards noted above will result in recoupment of payments.

Additional Information

Documentation

Documentation should not be repetitive (examples include, but are not limited to the following scenarios):

- Progress Notes that look the same for other recipients.
- Progress notes that state the same words day after day with no evidence of progression, maintenance or regression.
- Treatment Plans that look the same for other recipients.
- Treatment Plans with goals and interventions that stay the same and have no progression.

Progress Notes

- Progress Notes should not be ***preprinted*** or predated with the exception that a group therapy note may have a general section that identifies the participants (i.e. the number of participants, etc.), the topic, and a general description of the session which is copied for each participant. However, each participant must also have individualized documentation relative to his/her specific interaction in the group and how it relates to their treatment plan.

- The progress note should match the goals on the plan and the plan should match the needs of the recipient. The interventions should be

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appropriate to meet the goals. There should be clear continuity between the documentation.

- Progress Notes must provide enough detail and explanation to justify the amount of billing.

Treatment Plan

- The Treatment Plan should not be signed or dated prior to the plan meeting date.

Authentication

- Authors must always compose and sign their own entries (whether handwritten or electronic). An author should never create an entry or sign an entry for someone else or have someone else formulate or sign an entry for them. If utilizing a computer entry system, the program must contain an attestation signature line and time/date entry stamp.
    - If utilizing a computer entry system, there must be a written policy for documentation method in case of computer failure/power outage.

Corrections

Corrections must be made legally and properly by drawing a line through the entry and making sure that the inaccurate information is still legible. Write "error" by the incorrect entry and initial. Do not obliterate or otherwise alter the original entry by blacking out with marker, using whiteout, or writing over an entry. White Out, Liquid Paper, or any form of correctional fluid or correctional tape is not acceptable on **any** records whether being used as a corrective measure or to individualize an original template or for any other reason.

If Rehab Services are rendered to more than one eligible recipient in a household, the service documentation must include the following information:

All documentation must be individualized to each eligible recipient's visit.

There must be enough documentation in the recipient's file that support that the services rendered are specific to his/hers Treatment Plan.

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105.2.4 Requirements for Supervision/Monitoring and Complaint Procedure for Unlicensed Providers

Supervision/Monitoring

In order to regulate the quality of services performed by unlicensed allied mental health providers, all behavioral health services rendered by non-licensed individuals are required to be authorized by and performed under the supervision of a qualified supervisor as determined by the participating state agency (DMH/DHR/DYS).

Services provided by an individual in a clinical practicum authorized by the respective degree-granting institution will be supervised as required by that institution and by the supervising agency. Services provided by an individual with an approved master's degree that did not have a practicum or who are in the required post-master's internal practicum period must be supervised as required by the respective certifying state agency and the supervising agency's policies and procedures. Documentation of services provided by these individuals must meet all documentation requirements and be co-signed by the supervisor. Services rendered by individuals in these specific categories of supervision are billable under the supervisor's credential

Each participating state agency (DMH/DHR/DYS) must abide by their policy/guidelines that have been developed outlining any service billed to Medicaid under this chapter.

NOTE:
The permitting of unlicensed allied mental health professionals to provide services does not authorize as party to hold themselves out as a licensed professional or as titled professional for which a license is required.

Complaints

Complaints received to the Alabama Medicaid Agency against unlicensed providers will be forwarded to the appropriate state agency (employing the unlicensed provider) for investigation. Each participating state agency (DMH/DHR/DYS) must abide by their policy/guidelines that have been developed outlining complaint investigation procedure and submit a report of findings and actions taken (if any) to the Alabama Medicaid Agency. The Alabama Medicaid Agency may also conduct an investigation in reference to the received complaint.

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105.3 Prior Authorization and Referral Requirements

Rehabilitative services procedure codes generally do not require prior authorization. (PA), except for circumstances when a Rehab Option provider determines that it is medically necessary to provide treatment services that goes beyond the indicated service limits for a recipient eligible under EPSDT (under age 21). Medical necessity will be established from the recipient's condition at the time of the request, not the diagnosis alone. PA requests for such EPSDT service limits must be submitted to Gainwell within the designated timeframe for services requested utilizing the process as outlined at: www.medicaid.alabama.gov. To receive approval for a PA request, you must submit a complete request using the approved submission form(s) found at www.medicaid.alabama.gov. Form(s) must be legible, include physician's signature and must provide clinical documentation to support the requested EPSDT coverage request. It is the responsibility of the Rehabilitation Option service provider to obtain authorization prior to rendering the service. Direct all inquiries and requests relating to prior authorization for recipients eligible for EPSDT (under age 21) to the fiscal agent Provider Assistance Center at 1-800-688-7989.

This process applies to DMH (MI/SA) and DYS rehabilitative services providers only. DHR providers will continue with the EPSDT process that is currently in place.

Refer to Chapter 4, Obtaining Prior Authorization, for general guidelines. Rehabilitative services do not require an Alabama Coordinated Health Network (ACHN) referral.

105.4 Cost Sharing (Copayment)

Copayment does not apply to rehabilitative services.

105.5 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

Rehabilitative services providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claims processing turnaround
- Ability to immediately correct claim errors
- Online adjustments capability
- Enhanced access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When an attachment is required, a hard copy CMS-1500 claim form must be submitted.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

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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 - 10th Revision - Clinical Modification* (ICD-10-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, AMA Plaza 330 North Wabash Ave, Suite 39300 Chicago, IL 60611-5885, or 1-800-621-8335.

NOTE:

ICD-10 codes should be used for claims submitted with dates of service on/after 10/01/2015.

NOTE:

ICD-10 diagnosis codes, within the range of F0150-F69 and F90-F99 must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field. The Z code unspecified psychosocial circumstance is covered only for children and adolescents or adults receiving DHR protective services. Claims filed for pregnant women (SOBRA) must include V222 (pregnant state, incidental) as well as the appropriate MI/SA diagnosis code.

105.5.3 Procedure Codes and Modifiers

The (837) Professional and Institutional electronic claims and the paper claim have been modified to accept up to four Procedure Code Modifiers. Use the modifiers to distinguish mental illness/substance abuse, adult/child and adolescent, individual/group services.

Modifier 59 (Distinct Procedural Service)

Under certain circumstances eligible DMH MI-SA/DHR/DYS staff may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier 59 is used to identify procedures/services that are not normally reported together, but are appropriate under the circumstances. This may represent a different session or patient encounter, not ordinarily encountered or performed on the same day by the same eligible DMH MI-SA/DHR/DYS staff. *However, when another already established modifier is appropriate, it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used.*

According to the CPT book, modifier 59 is described as being necessary to describe a distinct procedural service. This modifier should only be used to show a distinct procedural service when a comprehensive/component coding pair is billed. Modifier 59 should not be billed to represent that multiple services of the same procedure code were performed.

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A comprehensive/coding pair occurs when one code is considered a component procedure and the other code is considered a comprehensive procedure. These code pairs are frequently referred to as bundled codes thus meaning the component code is usually considered an integral part of the comprehensive code. Therefore, in most instances the most comprehensive code only should be billed and the component code should be denied as re-bundled or mutually exclusive.

Modifier 59 should only be used in conjunction with a comprehensive/ coding pair procedure when appropriately unbundling the code pair. This modifier 59 should not be billed with the comprehensive code. The component code can be unbundled or allowed separately, in certain situations. If the two services are performed at two different times of day, then modifier 59 can be submitted with the component procedure code.

In order to communicate the special circumstances of the component/ comprehensive code pair unbundling, diagnoses codes must be utilized as appropriate on the claim form. In some cases, it may be necessary to attach a detailed explanation of services rendered to further explain the reason for the unbundling of code pairs.

CMS publishes the National Correct Coding Initiative Coding Policy Manual for Medicare and Medicaid Services (https://www.medicaid.gov/medicaid/program-integrity/ncci/index.html) and this may be used as a reference for claims-processing edits. The manual is updated annually, and the NCCI edits are updated quarterly. It is the responsibility of the provider to check the site quarterly for any billing-related updates.

105.5.4 Place of Service Codes

The following place of service codes applies when filing claims for rehabilitative services:

POS Code	*Description*
03	School
11	Office
12	Home
31	Skilled Nursing Facility or Nursing Home
32	Nursing Facility
33	Custodial Care Facility
34	Hospice
52	Psychiatric Facility Partial Hospitalization
53	Community Rehabilitative Services Center
55	Residential Substance Abuse Treatment Facility
56	Psychiatric Residential Treatment Center
99	Other Unlisted Facility

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105.5.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to Claims with Third Party Denials.

Refer to Section 5., Required Attachments, for more information on attachments.

105.5.6 Billing Instructions for Medical-related Services

Instructions for Claims with Dates of Service August 1, 2000 and Thereafter

1. Bill Medicare on a UB-04.
2. Services covered by Medicare should be automatically crossed over to Medicaid as a UB-04 outpatient crossover. If for some reason the claim never crosses over or the claim is denied after crossing over, send an Institutional Medicaid/Medicare-related claim form to Medicaid using the same information as it was sent to Medicare. Indicate coinsurance, deductible, and allowed amounts as applied by Medicare.
3. If Medicare does not pay on any part of the services, bill the amount due for the services on a CMS-1500 claim form using procedure codes listed in the provider manual. Please refer to the latest edition of the Provider Electronic Solutions User Manual for more information on submitting an override electronically. For paper claims, enter “key TPL input code M” in block 19 of the CMS-1500 form.

105.5.7 Billing Instructions for Medicare-Related Services

A. Partial Hospitalization Program – Medicare covers such services as education training, group therapy, activity therapy, etc. These services are billed to Medicare on a UB-04 claim using procedures codes (e.g. G0177, G0176, 90853, 90816, 90818, 90791, etc.).

1. Services **covered** by Medicare should be filed with Medicaid on a **Medical Medicaid/Medicare-related crossover claim form**, either electronically or on paper. Bundle all Medicare paid services together and use H0035-HE procedure code/modifier. Indicate the total coinsurance, deductible, allowed, and paid amounts as applied by Medicare.
2. Services **not covered** by Medicare should be filed with Medicaid as a straight Medicaid claim on a CMS-1500 claim form using the procedure codes listed in the provider manual since Medicaid covers these services. These claims must be submitted with an override code in order for Medicaid to consider payment and not reject the claim for Medicare coverage. For paper claims, enter *“key TPL input code M”* in block 19 of the CMS-1500 form. For an electronic override, submit a delay reason code of ‘11’. Please refer to the latest edition of the Provider Electronic Solutions User Manual for more information on submitting an override electronically.

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B. Service covered by Medicare rendered by Medicare enrolled provider (e.g., LCSW):

1. For the recipient with Medicaid/Medicare (non-QMB), the LCSW is covered by Medicare; but not Medicaid. After the payment has been received by Medicare; file Medicaid on **Medical Medicaid/Medicare-related crossover claim form** with the provider (clinic's) NPI and the clinic's secondary provider number. Do not file these claims using any of the LCSW's provider number.
2. For the recipient with QMB coverage, the LCSW is covered by Medicare and Medicaid. These claims will crossover from Medicare and Medicaid will process with the enrolled LCSW's provider number if billed appropriately to Medicare.

C. Medicaid Covered Service either not covered by Medicare or rendered by provider not allowed to enroll in Medicare:

1. For services not covered by Medicare or for services rendered by a provider not enrolled in Medicare, claims should be filed with Medicaid as a straight Medicaid claim on a CMS-1500 claim form using the procedure codes listed in the provider manual since Medicaid covers these services. These claims must be submitted with an override code in order for Medicaid to consider payment and not reject the claim for Medicare coverage. For paper claims, enter "key TPL input code M" in block 19 of the CMS-1500 form. For an electronic override, submit a delay reason code of '11'. Please refer to the latest edition of the Provider Electronic Solutions User Manual for more information on submitting an override electronically.

105.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
CMS-1500 Claim Filing Instructions	Chapter 5
Sterilization/Hysterectomy/Abortion Requirements	Chapter 5
Medical Necessity/Medically Necessary Care	Chapter 7
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
ASC Procedures List	Appendix I
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N

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106 Targeted Case Management

Case management services are comprehensive 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 cannot provide services in total care environments, such as nursing facilities, hospitals, and residential programs unless the recipients are in Adult Protective Services Target Group 7, or this target group includes individuals transitioning to a community setting. Case management services will be available for up to 180 consecutive days of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions. (State Medicaid Letter (SMDL), July 25, 2000). Also excluded are adults 21 and older receiving services in an Institution for Mental Disease (IMD).

Medicaid recipients may receive TCM services in more than one target group, or case management services from another program if the Agency determines this would not present a duplication of services. Refer to the section, “Duplicate Billing” in this chapter for additional information.

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	Intellectually Disabled Adults	Medicaid-eligible individuals age 18 and over who have been diagnosed with an intellectual disability.
Target Group 3	Disabled children	Medicaid-eligible individuals age 0-21 who are considered disabled
Target Group 4	Foster children	Medicaid-eligible individuals age 0-20 or until the individual reaches age 21 who are in the care, custody, or control of the state of Alabama
Target Group 5	Pregnant women	Medicaid-eligible women of any age in need of maternity services
Target Group 6	AIDS/HIV-positive individuals	Medicaid-eligible individuals of any age who have been diagnosed as having AIDS or being HIV-positive
Target Group 7	Adult protective service individuals	Medicaid-eligible individuals age 18 and over who are at risk of abuse, neglect, or exploitation
Target Group 8	Technology Assisted (TA) Waiver for Adults	Medicaid-eligible individuals age 21 and over who meet the eligibility criteria for the TA Waiver
Target Group 9	Individuals with a Diagnosed Substance Use Disorder	Medicaid-eligible individuals of any age who have been diagnosed with a substance use disorder.

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Target Group	*Recipients*	*Description*
Target 10	Disabled Children with ASD or SED and SMI Adults – High Intensity Care Coordination	Medicaid-eligible individuals age 0-20 or until the individual reaches age 21 who have Autism Spectrum Disorder (ASD) or a Serious Emotional Disturbance (SED) or an adult with a Severe Mental Illness (SMI) and requires High Intensity Care Coordination.

The policy provisions for TCM providers can be found in the *Alabama Medicaid Agency Administrative Code,* Chapter 40.

106.1 Enrollment

Providers/Subcontractors will submit a written request to the State Agency/Contractor for enrollment to the Targeted Case Management (TCM) Services Program. The request must contain the TCM target group to be covered: the name, address, and phone number of the provider agency; the name, address, and phone number of the payee (if different from the provider); the name and phone number of the contact person; and the tax ID number of the payee.

Subcontract providers must have a contract with the primary provider and be certified through the appropriate State Agency. A copy of this contract will be submitted with the request to enroll as a TCM provider.

A memo along with the Provider File Update Request Form must be forwarded to the Targeted Case Management (TCM) Unit with the assigned NPI, procedure code, and rate with the enrollment request information. This information will be sent to the Fiscal Agent Liaison and will be loaded to the pricing file.

The TCM Unit will notify the State Agency/Contractor of the effective date of enrollment in writing when the enrollment process has been completed.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

National Provider Identifier, Type, and Specialty

A provider who contracts with Alabama Medicaid as a TCM provider is added to the Medicaid system with the National Provider Identifiers provided at the time application is made. Appropriate provider specialty codes are assigned to enable the provider to submit requests and receive reimbursements for case management-related claims.

NOTE:

The 10-digit NPI is required when filing a claim.

TCM providers, with the exception of Target Group 9 providers, are assigned a provider type of 21 (Targeted Case Management). The assigned provider type for Target Group 9 is 11 (Mental Health). Valid specialties for TCM providers include the following:

- Mentally Ill Adults (209)

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- Intellectually Disabled Adults (229)
- Disabled Children (650)
- Foster Child (217)
- Pregnant Women (210)
- AIDS/HIV Positive Individuals (211)
- Adult Protective Services (640)
- Technology Assisted (TA) Waiver Eligible Adults (590)
- Individuals with a Diagnosed Substance Use Disorder (113)
- Autism Spectrum Disorder – High Intensity Care Coordination (212)

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

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106.1.1 Minimum Qualifications for Individual Targeted Case Managers

Individual Targeted Case Managers for target groups 1, 2, 3, 9, and 10 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, or possess certification as a registered nurse.

Individual Case Managers for Foster Children (Target Group 4) and Adult Protective Service individuals (Target Group 7) must be employed by DHR and meet the following qualifications:

- Possess a Bachelor of Arts or a Bachelor of Science degree, preferably in a human service field, or
- Possess certification as a registered nurse

In addition to the minimum educational requirements, Targeted Case Managers must complete training in a case management curriculum approved by Medicaid and other applicable state agencies. Specific requirements for each target group are listed in the following paragraphs.

106.1.2 Minimum Qualifications for Each Target Group

Minimum Qualifications for Target Group 1 Providers

TCM providers for Mentally Ill Adults (Target Group 1) must meet the minimum educational qualifications listed in Section 106. 1.1 and must complete training in a case management curriculum approved by Medicaid and the Department of Mental Health.

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 who have demonstrated the ability to provide targeted case management services directly, or the Alabama Department of Mental Health. TCM providers for Mentally Ill Adults must be certified and provide services through a contract with the Department of Mental Health.

Minimum Qualifications for Target Group 2 Providers

TCM providers for Intellectually Disabled Adults (Target Group 2) must meet the minimum educational qualifications listed in Section 106. 1.1 and must complete training in a case management curriculum approved by Medicaid and the Department of Mental Health.

The Alabama Department of Mental Health(ADMH) case management providers for Intellectually Disabled Adults (Target Group 2) will be Regional Boards incorporated under Act 310 of the 1967 Alabama Acts who has demonstrated the ability to provide targeted case management services directly, be ADMH employees or other contractors of ADMH.

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Minimum Qualifications for Target Group 3 Providers

TCM providers for Disabled Children (Target Group 3) must meet the minimum qualifications listed in Section 106.1.1 and must complete training in a case management curriculum approved by Medicaid.

The Alabama Department of Mental Health(ADMH) case management providers for Disabled Children (Target Group 3, Subgroup B-SED) must be Regional Boards incorporated under Act 310 of the 1967 Alabama Acts who have demonstrated the ability to provide targeted case management directly, or be ADMH employees. TCM providers for Disabled Children through DMH must be certified and provide services through a contract with "DMH." Act 310 provides for the formation of a public corporation to contract with ADMH in constructing facilities and operating programs for mental health services. A 310 Board has the authority to directly provide: planning, studies and services for mental illness.

The ADMH case management provider for Disabled Children (Target Group 3, Subgroup A- Intellectually Disabled and Target 3, Subgroup D14- Children with Autism Spectrum Disorder) must be Regional Boards incorporated under Act 310 of the 1967 Alabama Act who have demonstrated ability to provide targeted case management services directly, be ADMH employees, or other contractors of ADMH. Act 310 provides for the formation of a public corporation to contract with ADMH in constructing facilities and operating programs for mental health services. A 310 Board has the authority to directly provide: planning, studies and services for mental illness.

Minimum Qualifications for Target Group 4 Providers

TCM providers for Foster Children (Target Group 4) must meet the minimum educational qualifications listed in Section 106.1.1 and must complete training in a case management curriculum approved by Medicaid.

Minimum Qualifications for Target Groups 5 and 6 Providers

TCM providers for Pregnant Women (Target Group 5) and AIDS/HIV-Positive Individuals (Target Group 6) must meet the minimum qualifications listed in Section 106.1.1 and must complete training in a case management curriculum approved by Medicaid.

Minimum Qualifications for Target Group 7 Providers

TCM providers for Adult Protective Services (Target Group 7) must meet the minimum educational qualifications listed in Section 106.1.1 and must complete training in a case management curriculum approved by Medicaid.

Targeted Case Management Service Providers for Adult Protective Service Individuals (Target Group 7) must demonstrate experience with the target population in investigating abuse, neglect, or exploitation in domestic settings and in providing follow-up services to victims of abuse, neglect, or exploitation.

Minimum Qualifications for Target Group 8 Providers

TCM providers for Technology Assisted Waiver eligible adult individuals (Target Group 8) must meet the minimum qualifications listed in Section

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106.1.1 and must complete training in a case management curriculum approved by Medicaid.

Minimum Qualifications for Target Group 9 Providers

TCM providers for Individuals with a Diagnosed Substance Use Disorder (Target Group 9) must meet the minimum educational qualifications listed in Section 106.1.1 and must complete training in a case management curriculum approved by Medicaid and the Department of Mental Health.

TCM providers for Individuals with a Diagnosed Substance Use Disorder (Target Group 9) must be certified and provide services through a contract with the Department of Mental Health.

Minimum Qualifications for Target Group 10 Providers

TCM providers for Disabled Children with Autism Spectrum Disorder, Disabled Children with Serious Emotional Disturbance, and adults with Severe Mental Illness – High Intensity Care Coordination (Target Group 10) must meet the qualifications listed in Section 106.1.1 and must complete training in a case management curriculum approved by Medicaid.

The Alabama Department of Mental Health (ADMH) case management provider (for Target 10, Autism Spectrum Disorder (ASD)) must be Regional Boards incorporated under Act 310 of the 1967 Alabama Acts who have demonstrated the ability to provide targeted case management services directly, be ADMH employees, or other contractors of ADMH. Providers must be certified by the DMH and provide services through a contract with ADMH. Act 310 provides for the formation of a public corporation to contract with ADMH in constructing facilities and operating programs for mental health services. A 310 Board has the authority to directly provide: planning, studies and services for mental illness.

The ADMH case management provider (for Target 10, Serious Emotional Disturbance (SED) and Severely Mentally Ill (SMI)) must be either Regional Boards incorporated under Act 310 of the 1967 Alabama Act who have demonstrated ability to provide targeted case management services directly or be ADMH employees. Providers must be certified by the Alabama Department of Mental Health and provide services through a contract with ADMH. Act 310 provides for the formation of a public corporation to contract with the Alabama Department of Mental Health in constructing facilities and operating programs for mental health services. A 310 Board has the authority to directly provide: planning, studies and services for mental illness.

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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
- Billable/Non-Billable Services

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 recipient'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, they are considered direct activities and are billable:

- 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 completed assessment must be maintained in the recipient's file.

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

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- Resource analysis and planning

Case planning

TCM providers must develop a systematic, recipient-coordinated Plan of Care (POC). The POC lists the recipient's needs, strengths, and goals. The POC also lists the actions required to meet the identified needs of the recipient. It is based on the needs assessment and is developed through a collaborative process involving the recipient, their family or other support system and the case manager. It must be completed in conjunction with the needs assessment within the first **30 days** of contact with the recipient.

Service arrangement

Through linkage and advocacy, the case manager coordinates contacts between the recipient and the appropriate person or agency. These contacts may be face to face, phone calls, or electronic communication.

The POC lists the recipient's needs, strengths, and goals. The POC also lists the actions required to meet the identified needs of the recipient. It is based on the needs assessment and is developed through a collaborative process involving the recipient, their family or other support system and the case manager

A copy of the safety and/or crisis plan must be kept in the recipient's file.

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 POC 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.

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Target Group 1 – Mentally Ill Adults

Target Group 1 consists of functionally limited individuals age 18 and over with multiple needs who have been assessed by a qualified professional and have been found to require mental health case management. Such persons have a diagnosis included in the ICD-10 as appropriate to date of service (other than intellectual/developmental disabilities, autism spectrum disorder, organic mental disorder, traumatic brain injury, or substance abuse), impaired role functioning, and a documented lack of capacity for independently accessing and sustaining involvement with needed services.

Target Group 2 – Intellectually Disabled Adults

Target Group 2 consists of individuals who are 18 years of age or older with a diagnosis of intellectual disability, as defined by the American Association of Intellectually Disabled (formerly AAMD). The individual's diagnosis must be determined by a Qualified Intellectually Disabled Professional (QIDP) and must include a primary determination of both intellectual and adaptive behaviors indicating the individual's primary problems are due to being Intellectually Disabled. Such persons may have other or secondary disabling conditions.

Target Group 3 – Disabled Children

Target Group 3 consists of individuals, age 0-21 considered to be disabled as defined in the following six subgroups:

- Intellectually Disabled/related conditions
- Seriously emotionally disturbed
- Sensory impaired
- Disabling health condition(s)
- Developmentally disabled

Disabled Intellectually Disabled/Related Conditions

All recipients in this subgroup must be age 0-17. A recipient is considered Intellectually Disabled when a diagnosis of an intellectual disability is determined. This determination must include a primary determination of both intellectual and adaptive behaviors indicating the individual's primary problems are due to an intellectual disability.

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 being Intellectual Disabled because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of an intellectual disability persons, and requires treatment or services similar to those required for these persons
- Likely to continue indefinitely
- Results in substantial functional limitations in three or more of the following areas of major life activity:

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- Self-care
- Understanding and use of language
- Learning
- Mobility
- Self-direction or capacity for independent living

Seriously Emotionally Disturbed (SED)

In order to meet the definition of Seriously Emotionally Disturbed, the recipient must meet the following criteria (Diagnosis and Jeopardy of being Separated from Family) or (Diagnosis and Functional Impairment):

Diagnosis:

Must have a DSM/ICD diagnosis. A primary diagnosis of a "Z" code, substance use, autism spectrum disorder, developmental/intellectual disability, organic mental disorder, or traumatic brain injury does not meet the criteria.

Jeopardy of being Separated from Family (Out-of-Home Placement):

Still residing in the community, but in jeopardy of being separated from family as the result of a serious emotional disturbance.

Functional Impairments/Symptoms/Risk of Separation – Must have one of the following as the result of a serious emotional disturbance:

-Functional Impairment – Must have substantial impairment in one of the following capacities to function (corresponding to expected developmental level):

-Autonomous Functioning: Performance of the age appropriate activities of daily living, e.g., personal hygiene, grooming, mobility;

-Functioning in the community – e.g., relationships with neighbors, involvement in recreational activities;

-Functioning in the Family or Family Equivalent – e.g., relationships with parents/parent surrogates, siblings, relatives;

-**Functioning in School/work** – e.g., relationships with peers/teachers/co-workers, adequate completion of school work.

Symptoms – Must have one of the following:

-**Features associated with Psychotic Disorders**

-Suicidal or Homicidal Gesture or Ideation

-Risk of Separation: Without treatment, there is imminent risk of separation from the family/family equivalent or placement in a more restrictive treatment setting.

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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 disabled recipients have a visual impairment (either blind or partially sighted as defined above) and a concurring disabling condition.

Deaf disabled recipients have a hearing impairment (deaf as defined above) and a concurring disabling 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 exstrophy 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

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- Neoplasms such as leukemia, and retinoblastoma
- Multisystem genetic disorders such as tuberous sclerosis, and neurofibromatosis
- Autism Spectrum Disorder for a child or youth ages 0 to 21. In order to meet the definition of ASD, the recipient must meet the following criteria:
    - Must have a diagnosis of Autism Spectrum Disorder.
    - The individual has adaptive and/or maladaptive needs identified by established assessment criteria that require a multi-disciplinary service team from more than one eligible child-serving agency and/or are related to one or more co-occurring diagnoses.

Developmentally Disabled

A child age birth to three years is eligible for TCM services if they are experiencing developmental disabilities 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 developmental disability.

Disabled

A disabled individual who has a combination of two or more disabling conditions as described above is considered disabled. 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

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- The judicial determination or statutorily authorized action by the State to protect the child from actual or potential abuse under the Alabama Juvenile Code, Title 26, Chapter 14, Code of Alabama 1975, or other statute
- The voluntary placement agreement, voluntary boarding house agreement, or an agreement for foster care, between the State and the child's parent(s), custodian(s), or guardian

Target Group 5 – Pregnant Women

Target Group 5 consists of Medicaid-eligible women of any age in need of maternity services.

Target Group 6 – AIDS/HIV-Positive Individuals

Target Group 6 consists of Medicaid-eligible individuals of any age who have been diagnosed with AIDS or are HIV-positive as evidenced by laboratory findings.

Target Group 7 – Adult Protective Service Individuals

Target Group 7 consists of individuals 18 years of age or older who meet either of the following criteria:

- At risk of abuse, neglect, or exploitation
- At risk of institutionalization due to their inability or their caretaker's inability to provide the minimum sufficient level of care in the home

Target Group 8 - Technology Assisted (TA) Waiver for Adults

Target Group 8 individuals consist of Medicaid eligible individuals age 21 and older, who meet the eligibility criteria for the Technology Assisted (TA) Waiver for Adults.

Target Group 9 – Individuals with a Diagnosed Substance Use Disorder

Target Group 9 consists of Medicaid-eligible individuals who have a diagnosed substance use disorder or substance induced disorder, in accordance with criteria set forth by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association, and who meet the following additional criteria.

Individuals who:

- Have been unable to independently maintain a sustained period of recovery after repeated treatment episodes; or
- Have little or no access to community resources necessary to support sustained recovery efforts; or
- Have co-morbid conditions, as mental illness, emotional disorders, intellectual disabilities, medical conditions, sensory impairments, or mobility impairments; or
- Have significant responsibility for the care of dependents, as well as themselves

Target Group 10 – High Intensity Care Coordination.

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Intensive Care Coordination (ICC)—means a single case manager (and/or a single treatment team) and a treatment plan that guides the provision of all behavioral health and related support services.

Target Group 10 consists of individuals considered to be disabled as defined in the following three subgroups:

- Autism Spectrum Disorder (ASD) consists of individuals with Autism Spectrum Disorder, age 0-21.
- Seriously Emotionally Disturbed (SED) – consists of disabled children with Serious Emotional Disturbance, age 0-21.
- Severely Mentally Ill (SMI) – consists of disabled individuals with Serious Mental Illness, age 18 and older.

The population to be served consists of individuals age 0 to 20 or until the individual reaches age 21 considered to be disabled as defined in the following two subgroups and who require a multi-disciplinary service team from more than one child-serving agency or who have one or more co-occurring diagnoses;

Autism Spectrum Disorder

All recipients in this subgroup consists of individuals age 0 to 20 or until the individual reaches age 21.

In order to meet the definition of Autism Spectrum Disorder, the recipient must meet the following criteria:

- **Must have a diagnosis of Autism Spectrum Disorder.**

- **The individual has adaptive and/or maladaptive needs and caregiver needs identified by established assessment criteria that require a multi-disciplinary service team from more than one eligible child-serving agency and/or are related to one or more co-occurring diagnoses.**

Seriously Emotionally Disturbed

All recipients in this subgroup consists of individuals age 0 to 20 or until the individual reaches 21.

In order to meet the definition of Seriously Emotionally Disturbed, the recipient must meet the following criteria for (Diagnosis and Jeopardy of being Separated from Family) or Diagnosis and Functional Impairment) and require a multi-disciplinary service team from more than one child-serving agency or who have one or more co-occurring diagnoses.

- **Diagnosis**:

  - Must have a DSM/ICD diagnosis. A primary diagnosis of a “Z” code, substance use, autism spectrum disorder, developmental/intellectual disability, organic mental disorder, or traumatic brain injury does not meet the criteria.

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- **Jeopardy of being Separated from Family (Out-of-Home Placement):**

  -Still residing in the community but in jeopardy of being separated from family as the result of a serious emotional disturbance:

- **Functional Impairments/Symptoms/Risk of separation** – Must have one of the following as the result of a serious emotional disturbance:

- **Functional Impairment** – Must have substantial impairment in one of the following capacities to function (corresponding to expected developmental level):

  1. **Autonomous Functioning**: Performance of the age appropriate activities of daily living, e.g., personal hygiene, grooming, mobility;

  2. **Functioning in the community** – e.g., relationships with neighbors, involvement in recreational activities;

  3. **Functioning in the Family or Family Equivalent** – e.g. Relationships with parents/parent surrogates, siblings, relatives;

  4. **Functioning in School/work** – e.g., relationships with peers/teachers/co-workers, adequate completion of school/work.

-**Symptoms** – Must have one of the following:

  1. **Features associated with Psychotic Disorders**

  2. **Suicidal or Homicidal Gesture or Ideation**

  3. **Risk of Separation:**
     Without treatment, there is imminent risk of separation from the family/family equivalent or placement in a more restrictive treatment setting.

Severely Mentally Ill

All recipients in this subgroup consists of individuals age 18 and older considered to be disabled as defined in the following subgroup and who require a multi-disciplinary service team from more than one agency or who have one or more co-occurring diagnosis:

- Severely Mentally Ill (SMI): The population to be served consists of functionally limited individuals 18 years of age or older with multiple needs who have been assessed by a qualified professional and have been found to require mental health case management. Such

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persons have a diagnosis included in the ICD-10 as appropriate to date of service (other than primary developmental/intellectual disabilities, autism spectrum disorder, organic mental disorder, traumatic brain injury, or substance abuse), impaired role functioning, and a documented lack of capacity for independently accessing, and sustaining involvement with needed services.

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. **All documented entries must be legible, signed and dated by the person (identified by name and discipline) who is responsible for ordering, providing, or evaluating the service furnished. The author of each entry must be identified and must, either personally or electronically sign his or her entry. A stamped signature is not acceptable.**

Record retention for TCM files will remain three years plus the current year. Records for TCM provided through waivers shall be retained for three years during the initial waiver period and five years after renewal of the waivers.

Provider's records must contain the following information:

- Documented Referral Source
- Copy of completed Alabama Child and Adolescent Needs and Strengths Assessment (CANS), when applicable
- Medical and Psychological diagnosis
- Psychological and Medical test results performed by a qualified professional
- A systematic, recipient-coordinated Plan Of Care (POC). The POC should contain all 6 (six) core elements of TCM
- Verification that the recipient's Medicaid Eligibility was checked at admission and at least once a month, thereafter. NOTE: There are times when a recipient's eligibility status may change throughout the month. It is the provider's responsibility to ensure that a recipient has the applicable Alabama Medicaid coverage for the date(s) of service for which services will be provided. All providers must maintain a paper copy of the eligibility response in the patient's file. (For more information, refer to the Provider Manual, Chapter 3: Verifying Recipient Eligibility)
- Family history
- Educational history
- Medical history

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- Educational/vocational history
- Psychiatric treatment history
- Legal history
- Substance abuse history
- Mental status exam

TCM providers must maintain the following documentation in the recipient's record when billing for Foster Children (Target Group 4) and Adult Protective Service Individuals (Target Group 7):

- A current comprehensive service plan that identifies the medical, nutritional, social, educational, transportation, housing and other service needs that have not been adequately accessed
- A time frame to reassess service needs

Services must consist of at least one of the following activities:

- Establishment of a comprehensive case file for development and implementation of an individualized service plan to meet the assessed service needs of -the recipient
- Assistance for the recipient in locating needed service providers and making the necessary linkages to assure the receipt of services identified in the service plan
- Assessment of the recipient and service providers to determine that the services received are adequate in meeting the identified needs
- Reassessment of the recipient to determine services needed to resolve any crisis situation resulting from changes in the family structure, living conditions, or other events

Service Documentation

Documentation in the client’s record for each session, service, or activity for which Medicaid reimbursement is requested must include, the following:

- Name of recipient
- Date of service
- Name of provider agency and person providing services
- Nature, extent, and units of services provided
- Place of service
- The identification of the specific services rendered
- The signature of the staff person who rendered the services
- A written assessment of the client’s progress, or lack thereof, related to each of the identified clinical issues discussed
- All entries must be legible and complete and must be authenticated and dated (prior to being submitted for reimbursement) by the person (identified by name and discipline) who is responsible for ordering, providing, or evaluating

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the service furnished. The author of each entry must be identified and must authenticate his or her entry. Authentication may include handwritten signatures, written initials (for treatment plan reviews), or computer entry (associated with electronic records—not a typed signature). A stamped signature is not acceptable.

NOTE:

The documentation requirements described above will be applied to justify payment by Medicaid when clinical records are audited. Payments are subject to recoupment when the documentation is insufficient to support the services billed.

Service Documentation - Additional Information

Documentation should not be repetitive. Examples include, but are not limited to the following:

- Progress notes that look the same for other recipients.
- Progress notes that state the same words with no evidence of progression, maintenance, or regression.
- Plans of care that look the same for other recipients.
- Plans of care with goals and actions that stay the same and have no progression.

Progress Notes

- Progress notes should not be ***preprinted*** or predated with the exception that a group therapy note may have a general section that identifies the participants (i.e. the number of participants, etc.), the topic, and a general description of the session which is copied for each participant. However, each participant must also have individualized documentation that is specific to his/her interaction in the group and how it relates to their POC.
- The progress note should match the goals on the Plan of Care and the Plan of Care should match the needs of the recipient. The actions should be appropriate to meet the goals.
- Documentation must provide enough detail and explanation to justify the reimbursement requested.
- If Case Management (CM) services are rendered to more than one eligible recipient in a household on the same day, the case management documentation must include the following information:

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- All documentation must be individualized to each eligible recipient's visit

- There must be enough documentation in the recipient's file that support that the services rendered are specific to his/hers Person Centered Plan of Care

Authentication

- Authors must always compose and sign their own entries (whether handwritten or electronic). An author should never create an entry or sign an entry for someone else or have someone else formulate or sign an entry for them. If utilizing a computer entry system, the program must contain an attestation signature line and time & date entry stamp. A stamped signature is not acceptable.

- If utilizing a computer entry system, the program must contain an attestation signature line and time & date entry stamp. There must also be a written policy for documentation method in case of computer failure/power outage.

Social Services Work Sampling Study

For Target Group 4 (Foster Children) and Target Group 7 (Adult Protective Service Individuals), reimbursement rates are based on cost as determined by the quarterly Social Services Work Sampling Study. Rates will be adjusted annually based on the results of the previous four quarters. Random Moment Sampling may not be used as a method of documenting services provided to recipients. The Work Sampling Study must provide an audit trail that identifies each recipient whose case is included in the data used for rate formulation and identifies that services have been provided.

106.2.4 Limitations

For Target Group 4 (Foster Children) and Target Group 7 (Adult Protective Service Individuals), an encounter rate consisting of a maximum of one unit of case management services will be reimbursed per month for each eligible recipient receiving case management services. A unit of case management service consists of at least one telephone or face-to-face contact with the recipient, a family member, significant other, or agency from which the recipient receives or may receive services.

For Target Group 10 (Disabled Children with ASD, Disabled Children with SED, and Severely Mentally Ill Adults High Intensity Care Coordination), the monthly encounter rate for case management services is limited to one recipient per month. The payment rates were derived from an analysis of caseloads and staffing configurations, productivity, staffing costs and fee-for-service utilization. The caseloads and staffing configuration must adhere to the 1:18 ratio for Target Group 10. (Please refer to DMH policy as it refers to Low/High Intensity Care Coordination). For the provider to bill for a full month

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case rate, the recipient must maintain eligibility to receive services AND be enrolled with the provider during a period of **20 or more days**.

For all other target groups, a unit of service is reimbursed in increments of five minutes.

All contacts must appear in the recipient's record. Contacts must be for the coordination of services for a specific identified recipient. (Please refer to *Progress Notes* description in the **Service Documentation- Additional Information** section)

Recipients receiving case management services through a waiver are not eligible for targeted case management, except for Target Group 7 (Adult Protective Service Individuals). TCM for Group 7 may be provided in any setting including total care environments.

Case management services for Intellectually Disabled Adults are provided to individuals with a diagnosis of intellectual disability who are 18 years of age or older.

Case management services for all other target groups are not limited to a maximum number of hours per calendar year.

106.2.5 Billable/Non Billable Services

The following services are Direct and are billable:

Billable units are for time spent delivering a case management service. That service may occur face-to-face with the beneficiary or may consist of telephone contacts or mail or e-mail contacts necessary to ensure that the beneficiary is served.

In Target Group 4, 7 and 10, where payment is cost based, the case management rate can factor in the cost associated with mileage (in a cost-based payment methodology, by allocating such costs among all the productive time increments). It may also include the actual writing of case notes, time documenting social history and writing the information gathered for the case file for the development of a specific care plan; and the gathering of information and the actual documentation. The state may also document non-productive time by providing evidence of State or private agency policies regarding sick leave, vacation leave, paid holidays and training requirements. Any other non-productive time must be documented via use of a CMS approved time study.

Billable Services

The following services are examples of considered billable activities and are reimbursable under the Targeted Case Management Program:

- Meeting with the individual and the individual's team to complete case management plan/ISP/IEP.
- Telephone contact to gather information for an assessment.
- Visiting the day program/resident/community setting to meet with an individual and support staff to assess progress toward objectives.

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- Telephone calls and face to face meetings with family, friends, community members, and agencies for the purpose of developing, arranging for, or coordinating formal and informal supports.
- Reviewing records of providers of services to ensure proper documentation is in place.
- Providing an individual with information on advocacy groups, i.e. ADAP, Legal Aid.
- Documentation of assessments.
    - For targeted groups 1, 3, and 10, when providing care coordination services in an inpatient acute facility, psychiatric residential treatment center, Institute of Mental Disease (IMD), or any other facility within **180 consecutive days** of discharge from a medical institution, providers must bill the 'from and to' dates of the recipient's hospitalization, if known, in Form Locator 18 under 'Hospitalization Dates Related to Current Services' on the CMS-1500 claim for or the 837 equivalent.
    - If a provider bills Medicaid for case management services for a recipient with multiple hospital admissions and discharges within a month (for the target groups stated above), the provider must submit a separate claim form for each hospital admission and include the applicable discharge date. The hospitalization "from and to" dates must be indicated on the CMS-1500 Claim Form or the 837 equivalent, under "Hospitalization Dates" area.
    - All hospitalization "from and to dates" must be documented in the recipient's file. The documented hospitalization "from and to" dates documented in the recipient's file must match the hospitalization "from and to" dates on the submitted claim form.
    - A post payment review will be completed by Medicaid every 6 months to determine if payment was made inappropriately based the hospitalization policy described above.
    - Claims identified for services provided prior to the 180- day timeframe may be recouped.

Non-Billable Services

The following services are activities that are made on behalf of a group of individuals and not just a specific person, they are non-billable and are not reimbursable under the Targeted Case Management Program:

- Travel
- The actual scheduling of a meeting with an individual/family to complete the History and Profiles/SUN-R.
- Transporting an individual/family.
- Documentation of case notes and social history.
- Completing travel forms, leave slips, or any other general office activities, including copy work and other clerical activities.
- Visiting an individual who is in a hospital or nursing home. (Exception, services will be available for up to **180 consecutive days** of a covered stay in a medical institution).
- Visiting an individual in a prison or jail. ,
- Visiting an individual in an ICF/ID facility.
- Checking an individual's Medicaid eligibility.

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Duplicate Billing

Before providing Targeted Case Management (TCM) services, verify that the recipient is not receiving case management services through another Targeted Group or Waiver. If the recipient receives additional case management services, but the TCM services would not be duplicative, the Provider must document in writing to the Agency how their services would not present a duplication of services from other case management services received. The provider must have written approval from Medicaid prior to submitting the claim to the Agency for reimbursement for Targeted Case Management services. The Agency will pay for one case management fee per month and will recoup any claims paid in error unless the Agency has determined there is no duplication of services and gives prior approval for the TCM services provided.

In order to prevent duplicate billing, it is the responsibility of the Targeted Case Management Provider to check the recipient's eligibility at admission and monthly, as long as the recipient is receiving TCM services. If a provider requires training on checking the eligibility of recipients, they are encouraged to contact an Gainwell representative for assistance.

106.3 Prior Authorization and Referral Requirements

TCM procedure codes generally do not require prior authorization, except for the target groups noted below.

Targeted Case Management (TCM) providers must obtain prior authorization (PA) from the Alabama Medicaid Agency by submitting a PA request to Gainwell for TCM services in the following target groups:

- Target Group 3: Disabled Children except Target Group 3, Subgroup D14 – Children with Autism Spectrum Disorder
- Target Group 4: Foster Children
- High Intensity Care Coordination SED Children (Target Group 10)
- High Intensity Care Coordination ASD Children (Target Group 10)

Added: High Intensity Care…Target Group 10)

Direct all inquiries and requests relating to prior authorization for a specific target group to Gainwell Provider Communication Unit at 1(800) 688-7989.

Interagency Transfers

If a recipient in a target group requiring prior authorization (PA) requests to change service providers from one agency to another, the receiving TCM provider must complete a request for interagency transfer utilizing the *TCM Recipient Transfer Form*. This request authorizes Gainwell to reassign the PA number to the receiving agency providing the continuation of targeted case management services.

The *TCM Recipient Transfer Form* is a PA option in the Secure Provider Portal under the "Trade Files" tab.

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106.4 Cost Sharing (Copayment)

The copayment does not apply to services provided for targeted case management.

106.5 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

TCM providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claims processing turnaround
- Ability to immediately correct claim errors
- Online adjustments capability
- Enhanced access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When filing a claim on paper, a CMS-1500 claim form is required. Medicare-related claims must be filed using the Medical Medicaid/Medicare Related Claim Form.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

106.5.1 Time Limit for Filing Claims

Medicaid requires all claims for TCM providers to be filed within one year of the date of service. Refer to Section 5.1.5, Filing Limits and Approved Exceptions, for more information regarding timely filing limits and exceptions.

106.5.2 Diagnosis Codes

See Section 106.5.3 (Procedure Codes and Modifiers) for the allowable diagnosis codes. The *International Classification of Diseases - 10th Revision - Clinical Modification* (ICD-10-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, AMA Plaza 330 North Wabash Ave, Suite 39300 Chicago, IL 60611-5885, or 1-800-621-8335.

NOTE:

ICD-9 codes should be used for claims submitted with dates of service prior to or equal to 09/30/2015.

ICD-10 codes should be used for claims submitted with dates of service on/after 10/01/2015.

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NOTE:

ICD-9 or ICD-10 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

106.5.3 Procedure Codes and Modifiers

TCM providers use the Current Procedural Terminology (CPT) coding system. The CPT manual lists most required procedure codes. This manual may be obtained by contacting the Order Department, American Medical Association, 515 North State Street, Chicago, IL 60610-9986. The (837) Professional and institutional claims and the paper claim have been modified to accept up to four Procedure Code Modifiers.

The following procedure codes, modifiers, and diagnosis codes apply when filing claims for TCM services:

Target Group	*Procedure Code*	*ICD-10 Diagnosis Codes*	*PA Required?*
1 MI Adults	G9008-U1	F200 - F2089 F21 - F258 F28 F3011 - F308 F310 F3111 - F312 F3131 - F315 F3161 - F3164 F3171 - F3189 F320 - F328 F330 - F333 F3341 - F338 F340 - F348 F4001 - F4002 F4011 - F408 F410 - F418 F42 F440 - F4489 F450 - F451 F4521 - F4529 F458 F481 F488 F600 - F6089 F6811 - F688 F840 F843 - F848 F20.9 F25.9 F29 F30.10 F30.9 F31.10 F31.30 F31.60 F31.70 F31.9 F32 F32.9 F33.9 F34.9 F39	No

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Target Group	*Procedure Code*	*ICD-10 Diagnosis Codes*	*PA Required?*
		F40.00 F40.10 R452 R455 - R456	
2 Intellectually Disabled Adults	G9008-U2	F70 - F78	No
3 Intellectually Disabled Child	G9005-U3	F70 - F73	Yes
3 Disabled Child ASD	G9002-UA	F84.0 F84.1 F84.5 F84.9	Yes
3 SED Child	G9002-U3	F489 R455 - R456	Yes
3 Sensory Impaired Child	G9008-U3	R29818 R29898 R2990 - R2991	Yes
3 Disabling Health Child	G9008-U3	E035 F518 G4700 G4710 G4720 G4730 G478 - G476 R400 - R402344 R403 - R413 R4182 R419 - R42 R440 R442 - R443 R4583 - R4584 R502 - R509 R52 - R5383 R55 - R569 R61 R680 - R6812 R6881 R6883 R6889	Yes
3 Disabled Child	G9008-U3	Q079	Yes
3 DD Child	G9006-U3	F819 - F89	Yes
4 Foster Child	T2023-U4	F849	Yes
5 Pregnant Women	G9008-HD	M830O000 - O9A53	No
6 AIDS/ HIV	G9012-U6	B20 B9735 O98711 - O98713 O9872 - O9873	No
7 APSI	T2023-U7	R4181	No
8 TA Waiver	G9008-U5	Z430	No
9 SUD – Adults and Adolescents	G9008-U9	F1010 - F1099 F1110 - F1199 F1210 - F1299 F1310 - F1399 F1410 - F1499 F1510 - F1599 F1610 - F1699 F1810 - F1899 F1910 - F1999	No
10 Disabled Child ASD	G9003-UA	F84.0 F84.1 F84.5	Yes

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Target Group	*Procedure Code*	*ICD-10 Diagnosis Codes*	*PA Required?*
		F84.9	
10 Disabled Child SED	G9003-UA TG	F489 R455 – R456	Yes
10 Adults SMI	G9008-U1 TG	F200 – F2089 F21 – F258 F28 F3011 – F308 F310 F3111 – F312 F3131 – F315 F3161 - F3164 F3171 - F3189 F320 - F328 F330 - F333 F3341 - F338 F340 - F348 F4001 - F4002 F4011 - F408 F410 - F418 F42 F440 - F4489 F450 - F451 F4521 - F4529 F458 F481 F488 F600 - F6089 F6811 - F688 F840 F843 - F848 F20.9 F25.9 F29 F30.10 F30.9 F31.10 F31.30 F31.60 F31.70 F31.9 F32 F32.9 F33.9 F34.9 F39 F40.00 F40.10 R452 R455 - R456	No

For Target Group 10, the provider can use modifier ‘52’ to bill for a partial month

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106.5.4 Place of Service Codes

The following place of service codes apply when filing claims for TCM services:

POS Code	*Description*
02	Telehealth – Services provided through telecommunication technology
03	School
11	Office
12	Home
21	Inpatient Hospital (Medical)*
24	Ambulatory Surgical Center
33	Custodial Care Facility
51	Inpatient Psychiatric Facility*
52	Psychiatric Facility Partial Hospitalization
53	Community Mental Health Center
56	Psychiatric Residential Treatment Center*
62	Comprehensive Outpatient Rehabilitation Facility
71	State or Local Public Health Clinic
81	Independent Laboratory
99	Other – Other place of service not identified above

Allowed for Target Groups 1, 3, and 10. Claim must be billed with Hospitalization Dates Related to Current Services (CMS-1500 Form Locator 18 or 837 equivalent) completed.

For dates of service beginning December 1, 2020, use POS Code 99 for all claims billed with multiple dates of service (one-line item on a claim for a consecutive date range, i.e. span billing) when the services are provided in multiple locations. The documentation to support these claims must indicate the place of service and all other documentation criteria in Chapter 106.

106.5.5 Required Attachments

There are no required attachments for Targeted Case Management providers.

106.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
CMS-1500 Claim Filing Instructions	Chapter 5
Alabama Coordinated Health Network (ACHN)	Chapter 40
Electronic Media Claims (EMC) Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N

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107 Waiver Services

Medicaid covers Home and Community-Based Services (HCBS) through the Elderly and Disabled (E&D) Waiver, the State of Alabama Independent Living (SAIL) Waiver (formerly Homebound Waiver), the Technology Assisted (TA) Waiver for Adults, the Alabama Community Transition (ACT) Waiver, and the Community Waiver Program (CWP) to categorically needy individuals who would otherwise require institutionalization in a nursing facility.

Medicaid covers the Alabama Home and Community-Based Waiver for Persons with Intellectual Disabilities (ID Waiver), formerly MR Waiver the Living at Home (LHW) Waiver and the Community Waiver Program (CWP) to Medicaid-eligible individuals who would otherwise require the level of care available in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID).

The purpose of providing HCBS to individuals at risk of institutional care is to protect the health, safety, and dignity of those individuals while reducing Medicaid expenditures for institutional care. Services that are reimbursable through Medicaid's EPSDT Program shall not be reimbursed as a waiver service. HCBS are provided through a Medicaid waiver for an initial period of three or five years and for five-year periods thereafter upon renewal of waiver by the Centers for Medicare and Medicaid Services (CMS) .

The E&D Waiver is a cooperative effort between the Alabama Medicaid Agency, and the Alabama Department of Senior Services (ADSS). The policy provisions for E&D Waiver providers can be found in the *Alabama Medicaid Agency Administrative Code*, Chapter 36.

The SAIL Waiver is a cooperative effort between the Alabama Medicaid Agency and the Alabama-Department of Rehabilitation Services (ADRS). The policy provisions for SAIL Waiver providers can be found in the *Alabama Medicaid Agency Administrative Code*, Chapter 57.

The ID, LHW, and CWP Waivers are a cooperative effort between the Alabama Medicaid Agency and the Alabama Department of Mental Health (DMH). The policy provisions for ID, LHW, and CWP Waiver providers can be found in the *Alabama Medicaid Agency Administrative Code*, Chapters 35, 52, and 43 respectively.

The Alabama Medicaid Agency is the Operating Agency for the TA Waiver for Adults. The policy provisions for providers of the TA Waiver for Adults can be found in the *Alabama Medicaid Agency Administrative Code,* Chapter 54.

The ACT Waiver is a cooperative effort among the Alabama Medicaid Agency and Alabama Department of Senior Services (ADSS). The policy provisions for the ACT Waiver providers can be found in the Alabama Medicaid Agency Administrative Code, Chapter 44.

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NOTE:

Providers rendering private duty nursing services as a result of an EPSDT screening should refer to the Alabama Medicaid Provider Manual, Chapter 31 for policy provisions.

107.1 Enrollment

Applicants who meet the licensure and/or certification requirements of the State of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code* and the *Alabama Medicaid Provider Manual* should apply with the designated waiver Operating Agency for the E&D, SAIL, ID, LHW, CWP and ACT Waivers. Applicants for the TA Waiver are enrolled directly through Gainwell. The Operating Agency may contract directly with vendors of non-medical ACT Waiver services.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

National Provider Identifier, Type, and Specialty

A provider who contracts with Alabama Medicaid as a waiver provider is added to the Medicaid system with the National Provider Identifiers provided at the time application is made. Appropriate provider specialty codes are assigned to enable the provider to submit requests and receive direct reimbursement for waiver-related claims.

NOTE:

The 10-digit NPI is required when filing a claim.

Providers of waiver services are assigned a provider type of 53 (Waiver Service). Valid specialties for these providers include the following:

- Elderly and Disabled Waiver (670)
- SAIL Waiver (660)
- ID Waiver (680)
- Living at Home Waiver (690)
- Technology Assisted (TA) Waiver for Adults (590)
- ACT Waiver (661)
- CWP Waiver (685)

Enrollment Policy for Waiver Service Providers

To participate in the Alabama Medicaid Program, providers must meet the following requirements:

- Must have a contractual agreement with Medicaid directly or through an Operating Agency.
- Must meet the provider qualifications as outlined in the approved Waiver Document for the appropriate HCBS waiver.

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- Electronic visit verification is required for specified services under HCBS Waivers when conducted as part of service delivery for in home services. These services are electronically verified when the following information is electronically captured and submitted to Medicaid through the use of the State contracted EVVM system:
- (i) the type of service performed;
- (ii) the individual receiving the service;
- (iii) the date of the service;
- (iv) the location of service delivery;
- (v) the individual providing the service; and
- (vi) the time the service begins and ends

Re-enrollment Policy for Waiver Service Providers

Federal requirements mandate providers re-validate periodically with the Alabama Medicaid program. Providers will be notified when they are scheduled to re-validate. Failure to re-validate and provide appropriate documentation to complete enrollment will result in an end-date being placed on the provider file. Once a provider file has been closed for failure to timely re-validate, providers will have to submit a new application for enrollment.

107.2 Benefits and Limitations

The following table lists the services covered by each type of waiver:

Waiver	***Services Covered***
Elderly and Disabled Waiver	Case Management Services Homemaker Services Personal Care Services Adult Day Health Services Respite Care Services (Skilled) Respite Care Services (Unskilled) Companion Services Home Delivered Meals (Frozen Shelf-Stable and Breakfast Meals) Pest Control Service Skilled Nursing Services (RN/LPN) Home Modification Services Assistive Technology and Durable Medical Equipment (DME) Personnel Emergency Response System (PERS) (Installation Personnel Emergency Response System (PERS) (Monthly Monitoring Fee) Medical Supplies Supervisory Visits
SAIL Waiver	Case Management Services Personal Care Services Environmental Accessibility Adaptations Personal Emergency Response System (PERS) Initial Setup Personal Emergency Response System (PERS) Monthly Medical Supplies Minor Assistive Technology Assistive Technology Evaluation for Assisted Technology

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Waiver	*Services Covered*
	Assistive Technology Repairs Personal Assistance Services Unskilled Respite Care Pest Control Service
Home and community-based services for ID waiver	Residential Habilitation Training Services In-Home Residential Habilitation Training Services - Day Habilitation Services-(Levels 1-4) Day Habilitation Services w/transportation-(Levels 1-4) Prevocational Services Supported Employment Services Individual Job Coach Services Individual Job Developer Services Occupational Therapy Services Speech and Language Therapy Services Physical Therapy Services Positive Behavior Support Services-(Levels 1-3) Companion Services In-Home Respite Care Services Out-of-Home Respite Care Services Personal Care Services Personal Care on Worksite Services Personal Care Transportation Services Environmental Accessibility Adaptations Services Assistive Technology Services Specialized Medical Supplies Services Skilled Nursing Services (RN/LPN) Crisis Intervention Services Community Specialist Services Individual Directed Goods and Services Benefits and Career Counseling Services Community Experience Services Housing Stabilization Services Personal Emergency Response System Services Supported Employment Transportation Services Remote Supports Services

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Waiver	*Services Covered*
Home and community-based services for CWP waiver	Breaks and Opportunities (Respite) Services Community- Based Residential Services Integrated Employment Path Services Personal Assistance- Home Services Support Coordination Services Adult Family Home Services Assistive Technology and Adaptive Aids Services Co- Worker Supports Services Community Integration Connections and Skills Training Services Community Transportation Services Family Empowerment and Systems Navigation Counseling Services Financial Literacy Services Housing Counseling Services Housing Start-Up Assistance Services Independent Living Skills Training Services Individual Directed Goods and Services Minor Home Modifications Services Natural Support or Caregiver Education and Training Services Occupational Therapy Services Peer Specialist Services Personal Assistance- Community Services Physical Therapy Services Positive Behavioral Supports Services Remote Supports Services Skilled Nursing Services Speech and Language Therapy Services Supported Employment Individual Services Supported Employment Small Group Services Supported Living Services

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Waiver	*Services Covered*
Home and community-based services for Living at Home Waiver	In-Home Residential Habilitation Training Services Day Habilitation Services-(Levels 1-4) Day Habilitation Services w/transportation-(Levels 1-4) Supported Employment Services Supported Employment Transportation Individual Job Coach Services Individual Job Developer Services Prevocational Services In-Home Respite Services Out-of-Home Respite Services Personal Care Services Personal Care on Worksite Services Personal Care Transportation Services Physical Therapy Services Occupational Therapy Services Speech and Language Therapy Services Positive Behavior Support Services-(Levels 1-3) Skilled Nursing Services-(RN/LPN) Environmental Accessibility Adaptations Services Assistive Technology Services Specialized Medical Supplies Services Community Specialist Services Crisis Intervention Services Individual Directed Goods and Services Assistance in Community Integration Services Benefits and Career Counseling Services Community Experience Services Personal Emergency Response System Services Companion Services Housing Stabilization Services Remote Support Services
Home and community-based services for Technology Assisted (TA) Waiver for Adults	Private Duty Nursing (RN/LPN) Personal Care/Attendant Service Medical Supplies and Appliances Assistive Technology Pest Control Service
Home and community-based services for ACT Waiver	Community Case Management Transitional Assistance Services Personal Care Services Homemaker Services Adult Day Health Home Delivered Meals (Frozen, Shelf-Stable, and Breakfast) Respite Care Services (Skilled and Unskilled) Skilled Nursing Services (RN/LPN) Adult Companion Services Home Modification Services Assistive Technology Assistive Technology Repairs Assistive Technology Evaluations Personnel Emergency Response System (PERS) (Installation Personnel Emergency Response System (PERS) (Monthly Monitoring Fee) Medical Equipment, Supplies, and Appliances Personal Assistance Services Pest Control Services

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107.2.1 Financial Eligibility

Financial eligibility for the E&D waiver is limited to the following individuals:

- Individuals receiving SSI
- SSI related protected groups deemed to be eligible for SSI/Medicaid
- Individuals receiving State Supplementation
- Individuals receiving State or Federal Adoption Subsidy
- Optional categorically needy individuals at a special income level of 300 percent of the Federal Benefit Rate (FBR) who are receiving HCBS waiver services.

Financial eligibility for the ID waiver is limited to the following individuals:

- Individuals receiving SSI
- SSI related protected groups deemed to be eligible for SSI/Medicaid
- Special Home and Community-Based waiver disabled individuals whose income is not greater than 300 percent of the SSI Federal Benefit Rate
- Parents and Other Caretaker Relatives
- Federal or State Adoption Subsidy Individuals

Financial eligibility for the CWP waiver is limited to the following individuals:

- Individuals receiving SSI
- SSI related protected groups deemed to be eligible for SSI/Medicaid
- Special Home and Community-Based waiver disabled individuals whose income is not greater than 300 percent of the SSI Federal Benefit Rate
- Parents and Other Caretaker Relatives
- Federal or State Adoption Subsidy Individuals

Financial eligibility for the SAIL waiver is limited to the following individuals:

- Individuals receiving SSI
- SSI related protected groups deemed to be eligible for SSI/Medicaid
- Individuals receiving State Supplementation
- Special Home and Community-Based waiver disabled individuals whose income is not greater than 300 percent of the SSI Federal Benefit Rate

Financial eligibility for the Living at Home Waiver is limited to the following individuals:

- Individuals receiving SSI
- Parents and Other Caretaker Relatives
- SSI related protected groups deemed to be eligible for SSI/Medicaid
- Individuals receiving State or Federal Adoption Subsidy
- Special Home and Community-Based waiver disabled individuals whose income is not greater than 300 percent of the SSI Federal Benefit Rate

Financial eligibility for Technology Assisted Waiver for Adults is limited to the following individuals:

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- Individuals receiving SSI
- Special Home and Community-Based waiver disabled individuals whose income is not greater than 300 percent of the SSI Federal Benefit Rate
- State Supplementation
- Individuals eligible for the Pickle Program (continued Medicaid)
- Deemed disabled widow and widowers from age 50 but not yet age 60
- Early widow and widowers age 60-64
- Disabled adult children who lose Supplemental Security Income benefits upon entitlement to or an increase in the child's insurance benefits based on disability
- Individuals who would be eligible for SSI if not for deeming of income of parent(s) or a spouse
- Medicaid for Low Income Families (MLIF)

Financial eligibility for the ACT waiver is limited to the following individuals:

- Individuals receiving SSI
- SSI related protected groups deemed to be eligible for SSI/Medicaid
- Individuals receiving State Supplementation
- Special Home and Community-Based waiver disabled individuals whose income is not greater than 300% of the SSI Federal Benefit Rate

Financial determinations are made by the Alabama Medicaid Agency, or the Social Security Administration (SSA), as appropriate. In addition to the financial and medical eligibility criteria, Medicaid is limited by the number of recipients who can be served by the waiver.

107.2.2 Medical Eligibility

Medical eligibility criteria for the E&D, TA Waiver for Adults, and ACT Waivers are based on current admission criteria for nursing facility care. Admission criteria are described in Chapter 26 of the non-state Provider Manual, Nursing Facility.

The target groups for SAIL Waiver Services must meet the admission criteria for a nursing facility. The HCBS provider must specifically provide services to individuals with physical disabilities not associated with the process of aging and with onset prior to age 63.

SAIL waiver services are provided, but not limited, to persons with the following diagnoses:

- Quadriplegia
- Traumatic brain injury
- Amyotrophic lateral sclerosis
- Multiple sclerosis
- Muscular dystrophy
- Spinal muscular atrophy
- Severe cerebral palsy
- Stroke

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- Other substantial neurological impairments, severely debilitating diseases, or rare genetic diseases (such as Lesch-Nyhan Syndrome)

The target group, for ACT Waiver Services, is individuals currently residing in a nursing facility with a desire to transition to the community.

Eligibility criteria for HCBS for ID, CWP, and LHW recipients are the same as eligibility criteria for an ICF/IID facility. ID, CWP, and LHW persons who meet categorical medical and/or social requirements for Title XIX coverage will be eligible for HCBS under the waivers. 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 waivers.

107.2.3 Limitations

Medicaid does not provide waiver services to recipients in a hospital or nursing facility. However, case management activities are available through the Gateway to Community Living (GCL) initiative and the Hospital to Home (H2H) program to assist recipients interested in transitioning from an institution into a community setting under the waivers. Case management activities are limited to a maximum of 180 days prior to discharge into the community.

Medicaid or its operating agencies may deny home and community-based services if it determines that an individual's health and safety is at risk in the community; if the individual does not cooperate with a provider in the provision of services; or if an individual does not meet the goals and objectives of being on the waiver program.

NOTE:

SAIL waiver recipients must be age 18 years or older. LHW, CWP, & ID waiver recipients must be age 3 years or older. TA waiver recipients must be age 21 or with complex medical conditions who are ventilator dependent or who have tracheostomies.

107.2.4 Explanation of Covered Services

This section describes the covered services available through the HCBS Waiver Program. Please note that descriptions for services may differ from program to program.

Adult Day Health Services (S5102/Modifier UA - E&D) (S5102/Modifier TF UB-ACT)

Adult Day Health Service provides social and health care for a minimum of 4 hours per day in a community facility approved to provide such care. Adult Day Health Service includes health education, self-care training, therapeutic activities, and health screening.

Adult Day Health is provided by facilities that meet the minimum standards for Adult Day Health Centers as described in the HCBS Waiver for the E&D and ACT Waivers. The state agencies contracting for Adult Day Health Services must determine that each facility providing Adult Day Health meets the prescribed standards.

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A unit is defined as a per diem rate.

Homemaker Services (S5130/Modifier UA - E&D) (S5130/Modifier TF UB-ACT)

Homemaker services are general household activities that include meal preparation, food shopping, bill paying, routine cleaning and personal services. Homemaker Services are provided by a trained homemaker when the individual regularly responsible for these activities is temporarily absent or when a person is limited in managing the home and providing self-care.

A person providing homemaker services must meet the qualifications of a Homemaker Attendant as specified in the approved waiver document.

A unit is defined as 15 minutes.

Case Management Services (T1016/Modifier UA - E&D) (T1016/Modifier UB - SAIL) (T1016/Modifier TF UB-ACT)

Case management is a system under which a designated person or organization is responsible for locating, coordinating, and monitoring a group of services. A case manager is responsible for outreach, intake and referral, diagnosis and evaluation, assessment, care plan development, and implementing and tracking services to an individual. The case manager is also responsible for authorization of waiver and non-waiver services included in the recipient's care plan, terminations, and transfers and maintenance of recipient records.

Case management is provided by a case manager employed by or under contract with the state agencies as specified in the approved waiver document. The case manager must meet the qualifications as specified in the approved waiver document.

Case management activities may also be used to assist individuals residing in institutional settings, such as hospital and nursing facilities, to transition into community settings. Transitional case management services may be provided up to 180 days prior to discharge from an institution.

Transitional case management should not be billed until the first day a client is active on the waiver. If the individual fails to transition to the waiver, reimbursement will be at the administrative rate.

A unit is defined as 15 minutes.

Support Coordination Services CWP

(G9005 Support Coordination - Children/Transition-Age Youth Ages 3-21)

(G9005/Modifier HE Support Coordination - Children/Transition-Age Youth Ages 3-21)

(G9005/Modifier HI Support Coordination - Children/Transition-Age Youth Ages 3-21)

(G9005/Modifier HO Support Coordination - Children/Transition-Age Youth Ages 3-21)

(G9005/Modifier TF Support Coordination - Children/Transition-Age Youth Ages 3-21)

(G9005/Modifier TG Support Coordination - Children/Transition-Age Youth Ages 3-21)

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(G9008 Support Coordination - Adults Ages 22+)

(G9008/Modifier HI Support Coordination - Adults Ages 22+)

(G9008/Modifier HO Support Coordination - Adults Ages 22+)

(G9008/Modifier TF Support Coordination - Adults Ages 22+)

(G9008/Modifier HE Support Coordination - Adults Ages 22+)

(G9008/Modifier TG Support Coordination - Adults Ages 22+)

A case management and comprehensive supports/services coordination role involving direct assistance with gaining access to waiver program services that are desired by and selected by the individual, from among available services that are effective options for meeting one or more assessed needs. Support Coordination also involves the effective coordination of waiver program services with other Medicaid-funded services, other publicly funded services and programs (e.g. ADRS, school, workforce and generic community services), and other generic community services and resources (e.g. social, educational, religious, etc.) available to the individual, and family as applicable, regardless of the funding source.

A unit is defined as monthly.

Personal Care Services

Personal Care Services (T1019/Modifier UB - SAIL) (T1019/Modifier TF UB- ACT) (T1019/Modifier UA - E&D)

Personal Care Option (T1019/Modifier UB HX - SAIL) (T1019/Modifier TF HX - ACT) (T1019/Modifier UA HX- 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 is supervised by a registered nurse, and meets the qualifications of a Personal Care Attendant as specified in the approved waiver document.

Personal care services may be provided by a relative or a friend when documentation shows that a relative or friend is qualified and there is proof of a lack of other qualified providers in a remote area.

For the SAIL Waiver, the number of units and services provided to each client is dependent upon individual need as set forth in the client's Plan of Care established by the case manager. Personal care services may be provided for a period not to exceed 100 units (25 hours) per week and not to exceed a total of 5,200 units (1300 hours) per waiver year (October 1 – September 30) in accordance with the provider contracting period. Services may be reduced based on need.

Personal Care under the ACT Waiver - There is no unit limit for Personal Care under the ACT Waiver. Services are authorized based on the specific medical needs of the ACT Waiver participant.

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The Personal Choices program develops a new service delivery system for participants receiving personal care services on the State of Alabama Independent Living (SAIL) and ACT waivers that will allow for more participant involvement in the direction and choice of the person employed as a personal care worker.

Medicaid will not reimburse for activities performed which are not within the Scope of Services. State Plan EPSDT services must be exhausted prior to any use of Waiver services for individuals under the age of 21.

A unit is defined as 15 minutes.

Respite Care (T1005/Modifier UA - E&D) (T1005/Modifier TF UB-ACT) Respite Care Unskilled (S5150/Modifier UA - E&D), (S5150/Modifier TF UB-ACT)

Respite care is given to individuals unable to care for themselves on a short-term basis due to the absence or the need for relief of those persons normally providing the care. Respite care is provided in the individual's home and includes supervision, companionship and personal care of the individual.

Respite care may be provided by a companion/sitter, personal care attendant, home health aide, homemaker, LPN or RN, depending upon the care needs of the individual;

A unit is defined as 15 minutes.

Unskilled Respite Care (S5150/Modifier UB - SAIL)

Respite Care is provided to individuals unable to care for themselves and is furnished on a short-term basis because of the absence of or need for relief of those persons normally providing the care.

Unskilled Respite is provided for the benefit of the client and to meet client needs in the absence of the primary caregiver(s) rather than to meet the needs of the client’s household.

It is based on the needs of the individual client as reflected in the PCCP.

Breaks and Opportunities (Respite) Services CWP

(S5150 Breaks and Opportunities (Planned Respite) HOURLY - CWP); (S5150/Modifier HI/HW Breaks and Opportunities (Respite) Emergency Self-Directed DAILY); (S5150/Modifier HI Breaks and Opportunities (Respite) –Emergency DAILY); (S5150/Modifier HW/SE Breaks and Opportunities (Planned Respite) - Self-Directed DAILY – CWP); (S5150/Modifier HW Breaks and Opportunities (Planned Respite) - Self-Directed HOURLY – CWP); (S5150/Modifier SE Breaks and Opportunities (Planned Respite) DAILY – CWP)

A service provided to a waiver participant that lives with family or other natural supports who are providing support, care and supervision to the waiver participant. This service is provided for time-limited periods when the family or other natural supports are temporarily unable to continue to provide support, care and supervision to the waiver participant. This service can be provided in the waiver participant’s home or the pre-approved private home of the Breaks and Opportunities service provider. The Breaks and Opportunities service is provided with two equally important goals which include: (1) sustaining the family/natural support living arrangement and support-giving arrangement;

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and (2) providing the waiver participant with opportunities to continue his/her regular activities and relationships and/or to explore new opportunities and meet new people with the Breaks and Opportunities service provider.

This service is provided during specific periods of time in a day, week or month when the unpaid family/natural support-givers typically provide support, care and supervision to the waiver participant. This service is provided in a way that ensures the individual's typical routine and activities are not disrupted and the individual's goals and needs, as set forth in the PCP, are attended to without disruption.

A unit is defined as hourly or daily.

Companion Services (S5135/Modifier UA - E&D) (S5135/Modifier TF UB-ACT)

Companion services provide support and supervision that is focused on safety and non-medical care such as the following:

- Reminding recipient to bathe, to take care of personal grooming and hygiene, and to take medication
- Observing or supervision of snack and meal planning
- Accompanying recipient to necessary medical appointments and grocery shopping
- Assisting with laundry and light housekeeping duties that are essential to the care of the recipient.

Under no circumstances should any type of skilled medical service be performed. Companion services are provided in accordance with a therapeutic goal and are not purely recreational in nature. A person providing companion services must meet the qualifications of a companion worker as specified in the approved waiver document.

A unit is defined as 15 minutes.

Day Habilitation Services

(T2021/ Modifier UC/HW— ID-Level 1)

(T2021/Modifier UC/TF-ID-Level 2)

(T2021/Modifier UC/TG-ID-Level 3)

(T2021/Modifier UC/HK-ID-Level 4)

(T2021/Modifier UC/HW/SE-ID-Level 1-w/transportation)

(T2021/Modifier UC/TF/SE-ID-Level 2-w/transportation)

(T2021/Modifier UC/TG/SE-ID-Level 3-w/transportation)

(T2021/Modifier UC/HK/SE-ID-Level 4-w/transportation)

(T2021/Modifier UD/HW - LHW - Level 1)

(T2021/Modifier UD/TF - LHW - Level 2)

(T2021/Modifier UD/TG - LHW - Level 3)

(T2021/Modifier UD/HK – LHW – Level 4)

(T2021/Modifier UD/HW/SE – LHW – Level 1-w/transportation)

(T2021/Modifier UD/TF/SE – LHW – Level 2-w/transportation)

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(T2021/Modifier UD/TG/SE- LHW – Level 3-w/transportation)

(T2021/Modifier UD/HK/SE – LHW – Level 4-w/transportation)

Day Habilitation Service includes planning, training, coordination, and support to enable and increase independent functioning, physical health and development, communication development, cognitive training, socialization, community integration, domestic and economic management, behavior management, responsibility and self-direction. Staff may provide assistance/training in daily living activities and instruction in the skills necessary for independent pursuit of leisure time/recreation activities. Social and other adaptive skills building activities such as expressive therapy, prescribed use of art, music, drama or movement may be used to modify ineffective learning patterns and/or influence change in behavior.

Transportation cost to transport waiver recipients to places such as day programs, social events or community activities when public transportation and/or transportation covered under the State Plan is not available, accessible or desirable due to the functional limitations of the waiver recipient will be included in the rate paid to providers for this service. Day Habilitation Service workers may transport waiver recipients in their own vehicles as an incidental component of Day Habilitation Services.

Day Habilitation Training Services are provided by a residential staff and supervised by a Qualified Intellectual Disabilities Professional (QIDP) in coordination with the waiver recipient's Person-Centered Plan The residential staff will be required to complete the training requirements as outlined in the waiver document. The QIDP must provide and document supervision of, training for, and evaluation of Aide in the individual client record.*****The level utilized for Day Habilitation Services in the LHW is determined by the individual's ICAP score.

The provider for Day Habilitation Services can be reimbursed based on eight levels of services.

Day Habilitation Services are limited to 5 hours each day.

A unit is defined as 15 minutes.

Residential Habilitation Training Services (T2016/Modifier UC–ID)

Residential Habilitation is a type of residential service selected by the waiver recipient supported, offering individualized services and supports that enable the waiver recipient to acquire, retain, or improve skills necessary to reside in a community-based setting and which supports each waiver recipient's independence and full integration into the community, and ensures each waiver recipient's choice and rights.

Residential Habilitation Training Services provides habilitation training and intervention in the areas of self-care, sensory/motor development, interpersonal skills, communication, behavior shaping and supports, community living skills, mobility, health care, socialization, community inclusion, money management, pursuit of leisure and recreational activities and household responsibilities. Training and intervention may consist of incidental learning in addition to formal training plans and will also encompass modification of the physical and/or social environment.

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The rate paid to providers for Residential Habilitation Training Service includes the cost to transport waiver recipients to activities such as day programs, social events, or community activities when public transportation or transportation services covered under the Medicaid State Plan are not available. Residential Habilitation Training Service workers may transport consumers in their own vehicles as an incidental component of Residential Habilitation Training Services.

Residential Habilitation Training Services will be delivered or supervised by a Qualified Intellectual Disabilities Professional (QIDP) in accordance with the waiver recipient's Person-Centered Plan. Residential Habilitation Training services can also be delivered by a residential staff. The residential staff will work under supervision and direction of a QIDP.

The residential staff is required to be certified by the provider agency as having completed a course of instruction provided or approved by the DMH. Retraining will be conducted as needed, at least annually.

A unit is defined as a per diem rate.

Respite Care Services - In Home (S5150/Modifier UC - ID) (S5150/Modifier UD - LHW) (S5150/Modifier UC/HW- ID) (S5150/Modifier UD/HW – LHW)

Respite Care Services - Out-of-Home (T1005/Modifier UC –ID) (T1005/Modifier UD LHW) (T1005/Modifier UC/HW – ID) (T1005/Modifier UD/HW – LHW)

Respite Care Services are provided in or outside a family's home to temporarily relieve the unpaid primary caregiver. Respite Care Services provide short-term care to an adult or child for a brief period of rest or relief for the family from day to day care giving for a dependent family member.

Respite Care Services are typically scheduled in advance, but it can also serve as a relief in a crisis situation. As a crisis relief, Out of Home Respite Care Services can allow time and opportunity for assessment, planning and intervention to try to re-establish the waiver recipient in his home, or if necessary, to locate another home for him.

Respite Care Out of the Home Services are typically provided in a certified group home.

Respite Care Services cannot be provided by a family member.

A unit is defined as 15 minutes.

In-Home Residential Habilitation Training Services (T2017/Modifier UC – ID) (T2017/Modifier UD - LHW)

In-Home Residential Habilitation Training Services provide care, supervision, and skills training in activities of daily living, home management and community integration to a waiver recipient in their own homes, but not in group homes or other facilities.

Residential Habilitation Training Services include habilitation training and intervention in the areas of self-care, sensory/motor development, interpersonal skills, communication, behavior shaping, community living skills, mobility, health care, socialization, community inclusion, money management, pursuit of leisure and recreational activities and household responsibilities.

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Training and intervention may consist of incidental learning in addition to formal training plans, and will also encompass modification of the physical and/or social environment, meaning, changing factors that impede progress (e.g. moving a chair, substituting Velcro closures for buttons or shoe laces, changing peoples' attitudes toward the person, opening a door for someone, etc.) and provision of direct support, as alternatives to formal habilitative training.

Residential Habilitation Training Services for waiver recipients may be delivered or supervised by a QIDP in accordance with the waiver recipient's Person-Centered Plan. Residential Habilitation Training Services can also be delivered by a residential staff. The residential staff will work under supervision and direction of a QIDP.

The residential staff will be required to be certified by the provider agency as having completed a course of instruction provided or approved by the DMH/ID. Retraining will be conducted as needed, at least annually.

The rate paid to providers for Residential Habilitation Training Service includes the cost to transport waiver recipients to activities such as day programs, social events, or community activities when public transportation or transportation services covered under the Medicaid State Plan are not available.

In-Home Residential Habilitation Training Services is limited to 8 hours per day and cannot overlap other services.

Supported Employment (T2019/Modifier UC – ID) (T2019/Modifier UC/HN – ID) (T2019/Modifier UD/HN – LHW) (T2019/Modifier UC/HO – ID) (T2019/Modifier UD/HO – LHW) (T2019/Modifier UD – LHW) (T2019/Modifier UC/HW – ID) (T2019/Modifier UD/HW – LHW) (S0215/Modifier UC – ID) (S0215/Modifier UD – LHW)

There are three variations of Supported Employment Services: (1) Individual Assessment/Discovery (2) Small Group and (3) Individual.

1. Individual Assessment/Discovery is a one-time, time limited target service designed to help a waiver recipient who wishes to pursue individualized, integrated employment or self-employment. Discovery may involve a comprehensive analysis of the waiver recipient's history; interviews with family, friends and support staff/ observing the waiver recipient performing work skills; and career research in order to determine the waiver recipient's career interests, talents, skills, support needs and choice; and the writing of a Personal Profile Frames which will begin with the development of an employment plan.

2. Employment Small Group often consists of groups of waiver recipients being supported in enclave or mobile work crew activities. Employment Small Group are services and training activities provided in regular business, industry, and community settings for groups of two to eight workers with disabilities.

3. Employment Individual Services are the ongoing support to waiver recipients to obtain and maintain an individual job in competitive or customized employment, or self-employment, in an integrated work setting in the general workforce for which a waiver recipient is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by

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individuals without disabilities. Employment Individual includes two distinct services: Job Developer and Job Coach.

(a) The Job Developer duties include, but are not limited to, marketing the Supported Employment Service and the waiver recipient's skills; negotiating hours or location to meet the abilities of the waiver recipient; and job placement.

(b) The Job Coach enters once placement has been arranged. The Job Coach duties include, but are not limited to, assisting with training of waiver recipients in supported work to perform specific jobs consistent with their abilities; teaching waiver recipients associated work skills, responsibilities and behaviors not related to the specific job being performed; and providing continued ongoing support to waiver recipients in supported work.

Supported Employment Services are 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 (both group and individual) Services do not include facility based, or other similar types of vocational services furnished in specialized facilities that are not part of the general workplace.

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 P.L. 94-142.

Transportation accommodations to the worksite or supported employment provider's home-base should be a component of the planning process and integrated into the Person-Centered Plan. While developing the plan which will reflect employment goals; transportation issues, concerns, and access should be addressed. All avenues of possible sources of transportation should be considered including public transportation and natural supports such as family. If training is needed in order for a person to access transportation, then that training should be outlined in the plan.

Supported Employment Transportation Service can be authorized, under special circumstances, intended to be limited in scope, duration, and not to exceed the annual cap.

A unit is defined as 15 minutes.

Supported Employment Services (CWP)

(T2019/Modifier HE/HK Supported Employment-Small Group: 2-3)

(T2019/Modifier HI/HK Supported Employment-Small Group: 4)

(T2019/Modifier HE/HW/TF Supported Employment-Individual-Job Coaching: Months 7 - 12: <80% SELF-DIRECTED)

(T2019/Modifier HE/HW/TG Supported Employment-Individual-Job Coaching: 25+ Months: 40% - 64% SELF-DIRECTED)

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(T2019/Modifier HE/TF Supported Employment-Individual-Job Coaching: Months 13-24: 60% - 74%)

(T2019/Modifier HE/TG Supported Employment-Individual-Job Coaching: 25+ Months: 40% - 64%)

(T2019/Modifier HI/HW/TF Supported Employment-Individual-Job Coaching: Months 13-24: <60% SELF-DIRECTED)

(T2019/Modifier HI/HW/TG Supported Employment-Individual-Job Coaching: 25+ Months: <40% SELF-DIRECTED)

(T2019/Modifier HI/TF Supported Employment-Individual-Job Coaching: Months 13-24: <60%)

(T2019/Modifier HI/TG Supported Employment-Individual-Job Coaching: 25+ Months: <40%)

(T2019/Modifier HK/HW/SE Supported Employment-Individual-Job Development-SELF-DIRECTED)

(T2019/Modifier HK/HW Supported Employment-Individual-Job Development Plan-SELF-DIRECTED)

(T2019/Modifier HK/SE Supported Employment-Individual-Job Development Plan)

(T2019/Modifier HK Supported Employment-Individual-Job Development)

(T2019/Modifier HN/HW/TF Supported Employment-Individual-Job Coaching: Months 13-24: 60% - 74% SELF-DIRECTED)

(T2019/Modifier HN/HW Supported Employment-Individual-Discovery-SELF-DIRECTED)

(T2019/Modifier HN/TF Supported Employment-Individual-Job Coaching: Months 7 - 12: 90% - 100%)

(T2019/Modifier HN Supported Employment-Individual-Discovery)

(T2019/Modifier HO/HW/TF Supported Employment-Individual-Job Coaching: Months 7 - 12: 80% - 89% SELF-DIRECTED)

(T2019/Modifier HO/HW Supported Employment-Individual-Career Advancement: Job-SELF-DIRECTED)

(T2019/Modifier HO/TF Supported Employment-Individual-Job Coaching: Months 7 - 12: 80% - 89%)

(T2019/Modifier HO Supported Employment-Individual-Career Advancement: Job)

(T2019/Modifier HP/HW/TF Supported Employment-Individual-Job Coaching: Months 7 - 12: 90% - 100% SELF-DIRECTED)

(T2019/Modifier HP/HW Supported Employment-Individual-Career Advancement: Plan-SELF-DIRECTED)

(T2019/ Modifier HP/TF Supported Employment-Individual-Job Coaching: Months 7 - 12: <80%)

(T2019/Modifier HP Supported Employment-Individual-Career Advancement: Plan)

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(T2019/Modifier HW/SE/TF Supported Employment-Individual Exploration - SELF-DIRECTED)

(T2019/Modifier HW/SE/TG Supported Employment-Individual-Job Coaching: Months 13-24: 75% - 100% SELF-DIRECTED)

(T2019/Modifier HW/TF Supported Employment-Individual-Job Coaching: Months 1-6 SELF-DIRECTED)

(T2019/Modifier HW/TG Supported Employment-Individual-Job Coaching: 25+ Months: 65% - 100% SELF-DIRECTED)

(T2019/Modifier SE/TF Supported Employment-Individual Exploration)

(T2019/Modifier SE/TG Supported Employment-Individual-Job Coaching: Months 13-24: 75% - 100%)

(T2019/Modifier SE Co-Worker Supports-SE Agency Coordination and Oversight)

(T2019/Modifier TF Supported Employment-Individual-Job Coaching: Months 1-6)

(T2019/Modifier TG Supported Employment-Individual-Job Coaching: 25+ Months: 65% - 100%)

(T2019 Co-Worker Supports-Employer)

(H2023 Supported Employment Individual Job Coaching Stabilization & Monitoring)

(H2023/Modifier HW Supported Employment Individual Job Coaching & Monitoring Self-directed)

There are three variations of Supported Employment Services: (1) Individual Discovery, (2) Small Group and (3) Individual.

Supported Employment Individual is a progression of services provided, as needed, on an individual basis for a person who, because of their disability(s), needs support to obtain and/or maintain an individualized, competitive or customized job in an integrated community setting for which the person is compensated at or above the minimum wage. These services are designed to support the achievement of individualized integrated employment outcomes consistent with the person's employment/career goals and conditions for success, as determined through Exploration and/or Discovery if such services are needed to accurately identify these goals and conditions.

The expected outcome of this service is sustained paid employment in a competitive or customized job, with an employer who is not the person’s service provider, and for which a person is compensated at or above the minimum wage, but not less than the customary wage paid by the employer for the same or similar work performed by persons without disabilities. The job also offers the level of benefits offered to persons without disabilities performing the same/similar work.

Supported Employment—Individual Employment Support Services are individualized and may include the following components:

- Exploration: A time-limited & targeted service designed to help a person make an informed choice about whether to pursue an individualized, competitive or customized job in an integrated

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community setting for which compensation is at or above the minimum wage.

- Discovery: A time-limited & targeted service, if not otherwise available to the individual from the Alabama Department of Rehabilitative Services, designed to help a person, who wishes to pursue an individualized, competitive or customized job in an integrated community setting for which the person is compensated at or above the minimum wage, to identify through person-centered assessment, planning and exploration.
- Job Development Plan: A time-limited & targeted service, if otherwise not available to the individual from ADRS, designed to create a clear plan for Job Development to obtain an individualized, competitive or customized job in an integrated community setting for which the person is compensated at or above the minimum wage.
- Job Development: A service, if otherwise not available to the individual from ARDS, that supports a person to obtain an individualized, competitive or customized job in an integrated community setting for which the person is compensated at or above the minimum wage. This service is designed to implement the Job Development Plan, if applicable, & should result in the achievement of an individualized, integrated employment outcome consistent with the person's employment and career goals, as determined through Exploration (if necessary), Discovery (if necessary) &/or the employment planning process and reflected in the PCP.
- Job Coaching: A service for individualized, integrated employment, if not otherwise available to the individual from ADRS, includes identifying and providing services and supports that assist the person in maintaining and advancing in individualized employment in an integrated setting. Job Coaching includes supports provided to the person and their supervisor or co-workers, either remotely (via technology) or face-to-face. Job Coaching supports must be guided by a Job Coaching fading plan and must include systematic instruction utilizing task analysis to teach the person to independently complete as much of their job duties as possible.
- Career Advancement: A time-limited career planning and advancement support service, if not otherwise available to the individual from the Alabama Department of Rehabilitative Services, for persons currently engaged in individualized, integrated employment who wish to obtain a promotion and/or a second individualized, integrated employment opportunity. The service focuses on developing and successfully implementing a plan for achieving increased income and economic self-sufficiency through promotion to a higher paying position or through a second individualized, integrated employment or self-employment opportunity.

Supported Employment Small Group is a service providing employment services and training activities to support successful transition to individualized integrated employment or self-employment, or to supplement such employment and/or self-employment when it is only part-time.

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The expected outcome of this service is the acquisition of knowledge, skills and experiences that facilitate career development and transition to individualized integrated employment or self-employment, or that supplement such employment and/or self-employment when it is only part-time. The individualized integrated employment or self-employment shall be consistent with the individual's personal and career goals, as documented in their PCP. Supported Employment—Small Group shall be provided in a way that presumes all participants are capable of working in individualized integrated employment and/or self-employment.

Participants in this service shall be encouraged, on an ongoing basis, to explore and develop their interests, strengths, and abilities relating to individualized integrated employment and/or self-employment. In order to reauthorize this service, the PCP must document that such opportunities are being provided through this service, to the person, on an on-going basis. The PCP shall also document and address any barriers to the person transitioning to individualized integrated employment or self-employment if the person is not already participating in individualized integrated employment or self-employment.

A unit is defined as 15 minutes and monthly.

Prevocational Services (T2015/Modifier UC–ID)
(T2015/Modifier UD – LHW)

Prevocational Services are not available to waiver 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 a waiver recipient 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 waiver recipients not expected to be able to join the general work force or participate in a transitional sheltered workshop within one year (excluding supported employment programs).

Waiver recipients are compensated at a rate of less than 50 percent of the minimum wage.

A unit is defined as 1 hour.

Physical Therapy Services (97110/Modifier UC-ID) (97110/Modifier UD-LHW) (97110 – CWP)

Physical Therapy Services include services that assist in determining a waiver recipient's level of functioning by applying diagnostic and prognostic tasks and providing treatment training programs.

Physical Therapy Services preserve and improve abilities for independent function, such as range of motion, strength, tolerance, coordination, and activities of daily living.

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Physical Therapy Services 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 waiver recipient's family or foster family). The Physical Therapist must meet all state licensure requirements and be designated as a regulated Physical Therapist by the national accreditation body.

A unit is defined as 15 minutes.

Occupational Therapy Services (97535/Modifier UC –ID) (97535/Modifier UD – LHW) (97535 – CWP)

Occupational Therapy Services include the evaluation of a waiver recipient to determine level of functioning by applying diagnostic and prognostic tasks and guiding and treating waiver recipients in the prescribed therapy to secure or obtain necessary function.

Therapists may also provide consultation and training to staff or caregivers (such as waiver recipient's family or foster family). The Occupational Therapist must meet all state licensure requirements and be designated as a regulated Occupational Therapist by the national accreditation body.

A unit is defined as 15 minutes.

Speech and Language Therapy Services (92507/Modifier UC –ID) (92507/Modifier UD – LHW) (92507 – CWP)

Speech and Language Therapy Services are diagnostic, screening, preventive, corrective services provided on an individual basis, when referred by a physician (M.D., D.O.). Speech and Language Therapy Services may include:

- Screening and evaluation of waiver recipient’s speech and hearing functions and comprehensive speech and language evaluations when so indicated;
- Participation in the continuing interdisciplinary evaluation of waiver recipients for purposes of implementing, monitoring and following up on the person’s habilitation programs;
- Treatment services as an extension of the evaluation process that include:
    1. Consulting with others working with the waiver recipient for speech education and improvement
    2. Designing specialized programs for developing a waiver recipient’s communication skills comprehension and expression.

Therapists may also provide training to staff and caregivers (such as a waiver recipient's family and/or foster family). Services to direct caregivers will be allowed when the service to caregivers is for the direct benefit of the waiver recipient and is necessary to enable the waiver recipient to be cared for outside of an institution. The Speech/Language Therapist must meet all state licensure requirements.

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A unit is defined as an encounter.

Personal Emergency Response System (PERS) (S5160/Modifier UB - Installation - SAIL) (S5160/Modifier TF UB – Installation-ACT) (S5160/Modifier UA – Installation – E&D) (S5161/Modifier UB – Monthly - SAIL) (S5161/Modifier TF UB – Monthly-ACT) (S5161/Modifier UA – Monthly – E&D)

PERS is an electronic device that enables certain high-risk patients to secure help in the event of an emergency. The recipient may also wear a portable "help" button to allow for mobility. The system is connected to a patient's phone and programmed to signal a response center once a "help" button is activated. PERS must be provided by trained professionals. Initial setup and installation of PERS must be on the individual's plan of care, prior authorized and approved by the Alabama Medicaid Agency or its designee. The price quotation from the vendor shall specify the description of the PERS. Only one PERS installation per recipient can be approved. Exceptions to this limitation shall be considered on an individual basis for circumstances such as relocations.

A unit is defined as a monthly rate.

Personal Care (T1019/Modifier UC –ID) (T1019/Modifier UC/HW – ID) (T1019/Modifier UC/ HN) (T1019/Modifier UD – LHW) (T1019/Modifier UD/HW-LHW) (T1019/Modifier UD/HN – LHW)

Personal Care Services include assistance with any activity of daily living (ADL) or instrumental activity of daily living (IADL). Assistance for ADLs includes bathing, toileting, transfer and ambulation, skin care, grooming, dressing, extension of therapies and exercise, routine care of adaptive equipment primarily involving cleaning as needed, meal preparation, assistance with eating, and incidental household cleaning and laundry. IADLs include assistance with shopping, budgeting, using public transportation, social interaction, recreation, and leisure activities. Assistance with IADLs includes accompaniment, coaching and minor problem-solving necessary to achieve the objectives of increased independence, productivity and inclusion in the community.

While in general Personal Care Services will not be approved for a person living in a group home or other residential setting, under the ID Waiver and LHW, Personal Care Services may be approved by the Division of Development Disabilities for specific purposes that are not duplicative.

Personal Care Services can also include supporting a person at an integrated worksite where the individual is paid a competitive wage. There will be a separate procedure code for this service, provided at the worksite, to distinguish it from other personal care activities.

The personal care attendant will work under the supervision of a QIDP and will be observed every 90 days. The personal care attendant is also required to complete the training requirements prior to providing services.

No payment will be paid for Personal Care Services furnished by a member of the immediate family (e.g., parents spouses, children) living in the home or who have a legal obligation to provide Personal Care Services. Siblings who do not reside in the home with the waiver recipient can be paid to provide Personal Care Services to the waiver recipient.

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Personal Care Services may be self-directed to allow waiver recipients and their families to recruit, hire, train, supervise, and if necessary to discharge, their own personal care workers.

A unit is defined as 15 minutes.

Personal Care Transportation Services (T2001/Modifier UD – LHW) (T2001/Modifier UC – ID)

Personal care attendants may transport waiver recipients in their own (the attendant's) vehicles as an incidental component of the Personal Care Service. In order for this component to be reimbursed, the personal care attendant must be needed to support the waiver recipient in accessing the community, and not merely to provide transportation. The Personal Care Transportation Service will provide transportation into the community to shop, attend recreational and civic events, go to work and participate in *People First* and other community building activities. Additional payment will be made for mileage and the provider's cost of an insurance waiver to cover any harm that might befall the waiver recipient as a result of being transported.

The attendant must have a valid Alabama driver's license and his/her own insurance coverage as required by State law. The provider agency shall assure the attendant has a good driving record and is in-serviced on safety procedures when transporting a waiver recipient.

Personal Care Transportation Services shall not replace transportation that is already reimbursable under Day or Residential Habilitation nor the Medicaid non-emergency medical transportation program. The planning team must also assure the most cost-effective means of transportation, which would include public transport where available. Transportation by a personal care attendant is not intended to replace generic transportation nor to be used merely for convenience.

A unit is defined as a mileage rate.

Companion Services (S5135/Modifier UC –ID) (S5135/Modifier UD –LHW) (S5135/Modifier UC/HW – ID) (S5135/Modifier UD/HW –LHW)

Companion Services are non-medical supervision and socialization provided to a functionally impaired adult. Companions may assist the waiver recipient 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 waiver recipient.

Companion Service is provided in accordance with a therapeutic goal in the waiver recipient's approved plan of care and is not merely recreational in nature. Companion Service must be necessary to prevent institutionalization of the waiver 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.

Companion Services can be directed by waiver recipients or family but must adhere to all the traditional service rules.

A unit is defined as 15 minutes

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Positive Behavior Support Services
(H2019/Modifier UC/HP - ID - Level 1)
(H2019/Modifier UC/HN – ID- Level 2)
(H2019/Modifier UC/HM – ID-Level 3)
(H2019/Modifier UC/HP/SE – ID-Level 1)
(H2019/Modifier UC/HN/HM – ID – Level 2)
(H2019/Modifier UC/HM/SE – ID – Level 3)
(H2019/Modifier UD/HP – LHW – Level 1)
(H2019/Modifier UD/HN – LHW – Level 2)
(H2019/Modifier UD/HM – LHW – Level 3)
(H2019/Modifier UD/HP/SE – LHW – Level 1)
(H2019/Modifier UD/HN/SE – LHW – Level 2)
(H2019/Modifier UD/HM/SE – LHW – Level 3)
(H2019/Modifier/ HN – CWP – NON CRISIS CONSULTATION)
(H2019/CWP – CRISIS INTERVENTION AND STABILIZATION)

Positive Behavior Support (PBS) Services are a set of researched-based strategies that combine behavioral and biomedical science with person-centered, valued outcomes and systems change to increase quality of life and decrease problem behaviors by teaching new skills and making changes in a waiver recipient's environment. The strategies take into consideration all aspects of the waiver recipient's life and are intended to enhance positive social interactions across work, academic, recreational, and community settings while reducing actions that are not safe or that lead to social isolation, loneliness or fearfulness. PBS provides framework for approaches that emphasize understanding the waiver recipient, strengthening environment that build on individual strengths and interests, and decreasing interventions that focus on controlling problematic behavior in order to fit the waiver recipient's environment. Some of the billable tasks include, but are not limited to: conducting functional behavior support plan (BSP) development, training to implement the BSP, data entry/analysis/graphing, monitoring effectiveness of BSP, writing progress notes/reports, etc. BSP may include consultation provided to families, other caretakers and habilitation service providers. BSP shall place primary emphasis on the development of desirable adaptive behavior rather than merely the elimination or suppression of undesirable behavior. A behavior support plan may only be implemented after positive behavioral approaches have been tried and its continued use must be reviewed every thirty days with reports due quarterly.

Positive Behavior Support (PBS) Service is comprised of two general categories of service tasks. These are (1) development of a BSP and (2) implementation of a BSP. In addition, this waiver service has three service levels: two professional and one technical, each with its own procedure code and rate of payment. The service levels are distinguished by the qualifications of the service provider and by supervision requirements. Both professional and technical level service providers may perform tasks within both service categories, adhering to the supervision requirements that are described under provider qualifications.

The two professional service provider levels are distinguished by the qualifications of the person providing the service. Both require advanced

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degrees and specialization, but the top level also requires board certification in behavior analysis. The third service provider level is technical and requires that the person providing the service be under supervision to perform PBS tasks. There is a different code and rate for each of the three service provider levels.

The maximum units of service per year of both professional and technician level units combined cannot exceed 1200 and the maximum units of service of professional level one (1) or two (2) cannot exceed 800. Maximum units of Technician level service are the balance between billed professional level one (1) and two (2) units and the combined maximum per year. Providers who bill more than the 800 units of professional level will receive a denial notice. Once the denial notice is received, the provider should submit another claim for 800 units at the professional level and the remaining units at the technical level in order to receive payment for services rendered. Providers of service must document which tasks are provided by date performed in addition to their clinical notes. There will be no accommodation for exceeding the overall cap of 1200 units for all three levels.

Providers of service must maintain a service log that documents specific days on which services are delivered. The following do not qualify for billing under this waiver service: 1) individual or group therapy, 2) group counseling, 3) behavioral procedures not listed in a formal BSP or that do not comply with the current Behavioral Services Procedural Guidelines and Community Certification Standards, 4) non-traditional therapies, such as music therapy, massage therapy, etc., 5) supervision.

Providers at Level 1 must have either a Ph.D. or M.A. and be certified as a Behavior Analyst by the Behavior Analysis Certification Board.

Providers at level 2 must have either a Ph.D. or M.A. in the area of Behavior Analysis, Psychology, Special Education or a related field and three years of experience working with persons with developmental disabilities. Level 2 providers with a Doctorate do not require supervision.

Providers at Level 3 providers must be either a (QIDP) (per the standard at 43 CFR 483.430) or be a Board Certified Associate Behavior Analyst. Level 3 providers require supervision averaging at a minimum of one hour per week by either a Level 1 provider or a Level 2 Doctoral provider.

Positive Behavior Supports (PBS) for CWP involve expertise, training and technical assistance in evidence-based positive behavior support strategies to assist natural, co-worker and/or paid staff in supporting individuals who have behavioral support needs. Positive Behavior Supports are designed to improve the ability of unpaid natural supports and paid direct support staff to carry out therapeutic interventions. As needed, providers of Positive Behavior Supports conduct assessments, develop a person’s behavior support plan and train/consult with unpaid caregivers and/or paid support staff who are implementing the person’s behavior support plan, which is necessary to facilitate the person’s successful participation in the community, in employment and to ensure the person can remain in his/her current community living situation or transition to a less restrictive living situation.

This service may also include time-limited consultation with the person and his/her Person-Centered Planning team to consider available service providers and potential providers and assist the person to identify and select providers that can meet the unique needs of the member and to identify

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additional supports necessary to implement behavior plans and perform therapeutic interventions. As needed, this service is also used to allow the behavioral specialist to be an integral part of the person-centered planning team, as needed, to participate in team meetings.

All PBS service providers must complete an orientation training provided by DMH.

Positive Behavior Support can be directed by waiver recipients or family but must adhere to all the traditional service rules.

A unit is defined as 15 minutes.

Environmental Accessibility Adaptations Services (S5165/Modifier UB – SAIL) (S5165/Modifier UC –ID) (S5165/Modifier UC/HW – ID) (S5165/Modifier UD – LHW) (S5165/Modifier UD/HW – LHW)

Environmental modifications are those physical adaptations to the home, required by the waiver recipient's approved 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. Environmental Accessibility Adaptations must be necessary to prevent institutionalization of the waiver recipient.

Such adaptations may include the installation of ramps and grab-bars and/or the widening of doorways in order to accommodate the medical equipment and supplies necessary for the welfare of the waiver recipient.

Environmental Modifications exclude adaptations or improvements to the home which are not of direct medical or remedial benefit to the waiver recipient, such as floor covering, roof repair, central air conditioning, etc. Adaptations that add to the square footage of the home, any type of construction affecting the structural integrity of the home, changes to the existing electrical components of the home, or permanent adaptations to rental property are traditionally excluded from this Medicaid-reimbursed benefit. All services provided must comply with applicable state or local building codes. Environmental accessibility adaptations must be prior authorized and approved by the Alabama Medicaid Agency or its designee and must be listed on the waiver recipient's approved plan of care.

Total costs of environmental accessibility adaptations under the ID and LHW shall not exceed $5,000 per year, per waiver recipient.

Environmental Accessibility Adaptations for ID and LHW recipients can be directed by waiver recipients or family but must adhere to all the traditional service rules.

The SAIL Waiver maximum amount for this service is $8,500 per recipient for the entire stay on the waivers. Any expenditures in excess of $8,500 must be approved by the State Coordinator and the Medicaid designated personnel. This service may also be provided under the SAIL Waivers to assist an individual to transition from an institutional level of care to the SAIL Waivers. The modifications should not be billed until the first day the client is transitioned and has begun to receive waiver services in order to qualify as billable waiver expenditures. If the individual fails to transition to the SAIL Waivers, reimbursement will be at the administrative rate.

A unit is defined as an item.

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Assistive Technology Services
(T2029/Modifier UD - LHW) (T2029/Modifier UD/HW – LHW)
(T2029/Modifier UC-ID) (T2029/Modifier UC/HW –ID)

Assistive Technology includes devices, controls, or appliances specified in the waiver recipient's approved plan of care, which enable waiver recipients to increase their ability to perform activities of daily living or to perceive, control or communicate with the environment in which they live. Included items are those necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State Plan. Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State Plan and shall exclude those items which are not of direct medical or remedial benefits to the waiver recipient. Providers of Assistive Technology must maintain documentation of items purchased for each waiver recipient. All items shall meet applicable standards of manufacture, design and installation. Costs are limited to $5,000 per year, per waiver recipient.

Assistive Technology can be directed by individual participants or family members but must adhere to all the traditional service rules.

A unit is defined as an item.

Assistive Technology Services – CWP

(Assistive Technology and Adaptive Aids Assessment and/or Training (CWP T2029); (Assistive Technology and Adaptive Aids – DEVICES CWP ITEM (CWP T2029/Modifier/SE)

An item, piece of equipment or product system, whether acquired commercially, modified or customized, that is used to increase, maintain, or improve functional capabilities and to support the individual's increased independence in their home, in community participation, and in competitive integrated employment. The service covers purchases, leasing, shipping costs, and as necessary, repair of equipment required by the person to increase, maintain or improve his/her functional capacity to perform activities of daily living or instrumental activities of daily living independently or more cost effectively than would be possible otherwise. This service must include strategies for training the individual, natural/unpaid and paid supporters of the individual in the setting(s) where the technology and/or aids will be used, as identified in the Person-Centered Plan (PCP).

A unit is defined as hour or item.

Assistive Technology Services/Durable Medical Equipment

(T2029/Modifier UA - E&D)

An item, piece of equipment or product system, whether acquired commercially, modified, or customized, used to increase, maintain, or improve functional capabilities and support the individual's independence in the home, community, and integrated employment. The service covers purchases, leasing, shipping costs, and as necessary, repair of equipment required by the person to increase, maintain or improve his/her functional capacity to perform activities of daily living or instrumental activities of daily living independently or more cost effective. This service must include strategies for training the individual, natural/unpaid and paid supporters of the individual in the setting(s) where the technology and/or aids will be used, as identified in the person-centered plan (PCP).

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The maximum allowed for Assistive Technology Services/Durable Medical Equipment is $2,000 per year per waiver participant up to a total of $10,000 per waiver participant's lifetime. State Plan EPSDT services must be exhausted prior to any use of Waiver services for individuals under the age of 21.

A unit is defined as an item.

Specialized Medical Supplies Services
(T2028/Modifier UC-ID) (2028/Modifier UC/HW – ID) (T2028/Modifier UD-LHW) (T2028/Modifier UD/HW – LHW)

Specialized Medical Supplies are those which are specified in the waiver recipient's approved plan of care and are necessary to maintain the waiver recipient's health, safety and welfare, prevent further deterioration of a condition, or increase a waiver recipient's ability to perform activities of daily living. Supplies reimbursed under Specialized Medical Supplies shall not include common over-the-counter personal care items, supplies otherwise furnished under the Medicaid State plan, and items which are not of direct medical or remedial benefit to the waiver recipient. All items shall meet applicable standards of manufacture and design.

Providers of Specialized Medical Supplies must maintain documentation of items purchased for each waiver recipient. Costs for medical supplies are limited to $1800 per year, per waiver recipient.

Specialized Medical Supplies can be directed by waiver recipients or family but must adhere to all the traditional service rules.

A unit is defined as an item.

Assistive Technology (T2029/Modifier UB – SAIL)
(T2029/Modifier U5 - TA Waiver for Adults) (T2029/Modifier TF UB –ACT)

Assistive technology includes devices, pieces of equipment, or products that are modified or customized and are used to increase, maintain or improve functional capabilities of individuals with disabilities.

Assistive technology services also include any service that directly assists a disabled individual in the selection, acquisition, or use of an assistive technology device, including evaluation of need, acquisition, selection, design, fitting, customization, adaptation, and application. Items reimbursed with waiver funds are in addition to any medical equipment furnished under the State Plan and exclude those items which are not of direct medical or remedial benefit to the recipient. This service must be necessary to prevent institutionalization or to assist an individual to transition from an institutional level of care to the SAIL or ACT Waivers. All items shall meet applicable standards of manufacture, design and installation and must be listed on the client's plan of care. This service along with transitional assistive technology requires prior authorization and approval by the Alabama Medicaid Agency or its designee. Upon completion of the service, the client must sign and date a form acknowledging receipt of the service.

Vehicle modifications can only be authorized if it can be demonstrated that all Non-Emergency Transportation (NET) Services have been exhausted.

For the ACT Waiver, the combined amount for Assistive Technology, Assistive Technology Repair, and Evaluation for Assistive Technology, cannot exceed $15,000.

For the SAIL Waiver, Assistive Technology, cannot exceed $25,000.

A unit is defined as a per diem rate.

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Skilled Nursing (S9123/Modifier UC–RN; S9124/Modifier UC–LPN – ID) (S9123/Modifier UD – RN; S9124/Modifier UD–LPN – LHW) (S9123/Modifier UC/HW – ID); (S9124/Modifier UC/HW – ID) (S9123/Modifier UD/HW – LHW); (S9124/Modifier UD/HW – LHW) (S9123/Modifier TF UB-RN-ACT; S9124/Modifier TF UB-LPN-ACT) (S9123 - RN – CWP; S9123/Modifier/HW – CWP); (S9124 – LPN – CWP; S9124 LPN/Modifier/HW – CWP) (S9123/Modifier UA – RN; S9124/Modifier UA – LPN – E&D)

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.

Services available for Participant Direction services under Personal Choices Program State Plan Option, 1915(j) are: Personal Care, Homemaker, Unskilled Respite, and Companion. Skilled Nursing is not an allowable service under the 1915(j) because the provisions do not fall within the guidelines of the Alabama Nurse Practice Act.

State Plan EPSDT services must be exhausted prior to any use of Waiver services for individuals under the age of 21. Skilled Nursing Service is not intended to be provided seven (7) days a week/24 hours a day and is not intended to be a private duty arrangement. The provision of Skilled Nursing Services must be ordered by a physician and documented in the person-centered plan of care. Services provided without an order by the physician will not be reimbursed by the Alabama Medicaid Agency.

A unit is defined as 1 hour.

Medical Supplies (T2028/Modifier UB – SAIL) (T2028/Modifier TF UB-ACT) (T2028/Modifier UA – E&D)

Medical supplies are necessary to maintain the recipient's health, safety, and welfare and to prevent further deterioration of a condition such as decubitus ulcers. These supplies do not include common over-the-counter personal care items such as toothpaste, mouthwash, soap, shampoo, Q-tips, deodorant, etc.

These medical supplies will only be provided when authorized by the recipient's physician and shall meet applicable standards of manufacture, design and installation. Providers of this service will be those who have a signed provider agreement with Medicaid and the Department of Rehabilitation Services. Medical supplies are limited to $2,100.00 per recipient per year. The OA must maintain documentation of items purchased for the recipient.

For the E&D Waiver, Medical Supplies shall be billed monthly, quarterly or annually. The yearly allotment cap shall not exceed $1,200.00 If billed monthly, the monthly cap amount shall not exceed $100.00. If billed quarterly, the quarterly cap amount shall not exceed $300.00. Total cap amounts shall not rollover to another month, quarter or year. State plan EPSDT services must be exhausted prior to any use of waiver services for individuals under the age of 21.

A unit is defined as a per diem rate.

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Evaluation for Assistive Technology (T2025/Modifier UB - SAIL) (T2025/Modifier TF UB –ACT)

This service will provide for an evaluation and determination of the client's need for assistive technology. The evaluation must be physician-prescribed and be provided by a physical therapist licensed to do business in the state of Alabama who is enrolled as a provider with the Alabama Department of Rehabilitation Services (ADRS).

When applicable, a written copy of the physical therapist's evaluation must accompany the prior authorization request, and a copy must be kept in the recipient's file. This service must be listed on the recipient's plan of care before being provided. Reimbursement for this service will be the standard cost per evaluation, as determined by Alabama Medicaid or its designee. This service must be necessary to prevent institutionalization of the recipient.

This service may also be provided to assist an individual to transition from an institutional level of care to the home and community-based waiver. The service should not be billed until the first day the client is transitioned and has begun to receive waiver services in order to qualify as billable waiver funds. If the individual fails to transition to the SAIL Waiver, reimbursement will be at the administrative rate.

For the ACT Waiver, the combined total of Assistive Technology, Assistive Technology Repair, and Assistive Technology Evaluation cannot exceed $15,000.

A unit is defined as a per diem rate.

Assistive Technology Repairs (T2035/Modifier UB - SAIL) (T2035/Modifier TF UB –ACT)

This service will provide for the repair of devices, equipment or products that were previously purchased for the recipient. The repair may include fixing the equipment or devices, or replacement of parts or batteries to allow the equipment to operate. This service is necessary to ensure health and safety and prevent institutionalization. All items must meet applicable standards of manufacture, design and installation. Repairs must be arranged by the case manager and documented in the plan of care and case narrative. Prior authorization is not required for this service.

For the ACT Waiver, the combined total of Assistive Technology, Assistive Technology Repair, and Assistive Technology Evaluation cannot exceed $15,000.

A unit is defined as a per diem rate.

Minor Assistive Technology (T2028 UB SC- SAIL)

Minor Assistive Technology (MAT) includes supplies, devices, controls, or appliances, specified in the Plan of Care, which enable individuals to increase their ability to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. All MAT supplies must be prescribed by a physician, be medically necessary and be specified in the Plan of Care. MAT is necessary to maintain the recipient's health, safety, and welfare and to prevent further deterioration of a condition and does not include common over the counter personal care items.

The OA must maintain documentation of items purchased for the recipient. Providers of this service will be those who have a signed provider agreement

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with the Alabama Medicaid Agency and the Department of Rehabilitation Services.

Vendors providing MAT devices should be capable of supplying and training in the use of the minor assistive technology/device.

A unit is defined as a daily rate.

Waiver Frozen Meals (S5170/Modifier UA - E & D) (S5170/Modifier TF UB- ACT)
Waiver Shelf-Stable Meals (S5170/Modifier SC - E & D) (S5170/Modifier TF SC- ACT)
Breakfast Meals (S5170 - E & D) (S5170/Modifier TF UA- ACT)

Home Delivered meals are provided to an individual who is unable to meet his/her nutritional needs. It must be determined that the nutritional needs of the individual can be addressed by the provision of home delivered meals. (The individual must be age 21 or older to receive this service on the E&D waiver.)

This service will provide at least one (1) nutritionally sound meal per day to adults unable to care for their nutritional needs because of a functional disability dependency, who require nutritional assistance to remain in the community and do not have a caregiver available to prepare a meal for them. Meals provided by this service will not constitute a full daily nutritional regimen.

This service will be provided as specified in the plan of care.

A unit is defined as:

Seven-(7) pack of frozen meals equal to 1 unit.

Two (2) shelf-stable meals equal to 1 unit.

Seven-(7) pack of breakfast meals equal to 1 unit.

Personal Assistance Services (S5125/Modifier UB – SAIL)
(S5125/Modifier TF UB- ACT)

Personal Assistant Services (PAS) are a range of services provided by one or more persons designed to assist an individual with a disability to perform daily activities on and off the job. These activities would be performed by the individual, if that individual did not have a disability. Such services shall be designed to increase the individual's independence and ability to perform every day activities on and off the job.

This service will support that population with physical disabilities who are seeking competitive employment either in their home or in an integrated work setting. An integrated work setting is defined as a setting typically found in the community, which employs an individual with disabilities and there is interaction with non-disabled individuals who are in the same employment setting.

This service must be sufficient in amount, duration, and scope such that an individual with a moderate to severe level of disability would be able to obtain the support needed to both live and get to and from work.

A unit is defined as 15 minutes.

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Personal Assistance Services– CWP

(S5125 – Personal Assistance Community); (S5125/Modifier HW – Personal Assistance Community Self-directed); (S5125/Modifier HE Personal Assistance Home); (S5125/Modifier HE/HW Personal Assistance Home Self-directed); (S5125/Modifier HE/HO/HW - Personal Assistance Home: Family Self-directed)

A range of services and supports designed to assist an individual with a disability to perform, participate fully in his/her community and supports for activities of daily living and instrumental activities of daily living that the individual would typically do for themselves if they did not have a disability and that occur outside the home.
Personal Assistance-Community services may be provided outside the person's home, at an integrated workplace where the person is paid a competitive wage, or other places in the broader community to support community participation, involvement and contribution by the person.

Personal Assistance-Community services must be provided consistent with the goals/outcomes defined in the Person-Centered Plan and with the over-arching goal of ensuring the individual's full community participation and inclusion. Participant goals and support needs, as documented in the Person-Centered Plan, shall be addressed by the Personal Assistance-Community provider in a manner that supports and enables the individual to achieve the highest level of independence possible.

Personal Assistance-Community may be used to address assistance needs in the workplace and community, if personal care and assistance are the only type of supports an individual needs in these locations. Otherwise, personal care and assistance is included in Supported Employment or Community Integration Connections and Skills Training services and the provider of those services shall be responsible for these needs during the hours that Supported Employment on-the-job supports (i.e. Individual Job Coaching or Small Group supports) or Community Integration Connections and Skills Training services are provided. As appropriate to the individual need, based on the nature of the community involvement, this service includes assistance, support, supervision and partial participation with eating, toileting, personal hygiene and grooming, and other activities of daily living as appropriate and needed to sustain competitive integrated employment, integrated community participation, involvement and contribution.

Personal Assistance- Home is a range of services and supports designed to complement but not supplant natural supports and assist an individual with a disability to perform, in his/her home, activities of daily living, including instrumental activities of daily living that the individual would typically do for themselves if they did not have a disability. Personal Assistance-Home services are provided in the person's home and outside the home on the property where the home is located. Participant goals and support needs, as documented in the Person-Centered Plan, shall be addressed by the Personal Assistance-Home provider in a manner that supports and enables the individual to acquire, retain and maximize skills and abilities to achieve the highest level of independence possible. Services, if needed, to support goals and needs related to instrumental activities of daily living that occur outside the home (e.g. shopping; banking), competitive integrated

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employment and community participation, involvement and contribution must also be addressed in the Person-Centered Plan using Personal Assistance-Community, other appropriate services, or available natural supports. Natural supports must be documented in the Person-Centered Plan and confirmed by the Support Coordinator.

A unit is defined as 15 minutes.

Personal Care/Attendant Service (T1019/Modifier U5 – TA Waiver for Adults)

Personal Care/Attendant Service (PC/AS) provides in-home and out-of-home (job site) assistance with eating, bathing, dressing, caring for personal hygiene, toileting, transferring from bed to chair and vice versa, ambulation, maintaining continence, medication management and other activities of daily living (ADLs). It may include assistance with independent activities of daily living (ADLs) such as meal preparation, using the telephone, and household chores such as laundry, bed-making, dusting and vacuuming, which are incidental to the assistance provided with ADLs or essential to the health and welfare of the client rather than the client's family.

PC/AS is designed to increase an individual's independence and ability to perform daily activities and to support individuals with physical disabilities in need of these services as well as those seeking or maintaining competitive employment either in the home or an integrated work setting.

A unit is defined as 15 minutes.

Medical Supplies and Appliances (T2028/Modifier U5 – TA Waiver for Adults)

This service includes medical equipment and supplies that are not covered in the Medicaid State Plan. The medical equipment or supplies must be included in the recipient's plan of care, and they must be necessary to maintain the recipient's ability to remain in the home. This service must be necessary to avoid institutionalization of the recipient. Invoices for medical equipment and supplies must be maintained in the case record

A unit is defined as a per diem rate.

Private Duty Nursing (S9123/Modifier U5 – RN; S9124/Modifier U5 – LPN - TA Waiver for Adults)

The Private Duty Nursing Service is a service which provides skilled medical observation and nursing services performed by a Registered Nurse or Licensed Practical Nurse who will perform their duties in compliance with the Nurse Practice Act and Alabama State Board of Nursing. Private Duty Nursing under the waiver will not duplicate Skilled Nursing under the mandatory home health benefit in the State Plan. If a waiver client meets the criteria to receive the home health benefits, home health should be utilized first and exhausted before Private Duty Nursing under the waiver is utilized. The objective of the Private Duty Nursing Service is to provide skilled medical monitoring, direct care, and intervention for individuals 21 and over to maintain him/her through home support. This service is necessary to avoid institutionalization and the individual must meet criteria outlined in the approved waiver document prior to receipt of services.

A unit is defined as 1 hour.

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Community Specialist Services (H2015-UD – LHW) (H2015-UC – ID) (H2015/Modifier UC/HW – ID); (H2015/Modifier UD/HW – LHW)

Community Specialist Services is a time limited, task specific service that may include professional observation and assessment, facilitation of Person-Centered Plan development and continuance, individualized program design and implementation, training of waiver recipients and family members, consultation with caregivers and other agencies, and monitoring and evaluation of planning and service outcomes as needed to facilitate and implement the Person-Centered Plan. Community Specialist Services, at the choice of the waiver recipient or family, include advocating for the consumer and assisting him or her in locating and accessing services and supports. The Community Specialist will serve as both a qualified planner and, at the waiver recipient's or family's request, a broker.

The functions outlined for Community Specialist Services differs from case management in the skill level and independence of the Specialist, as well as the focus on self-determination and advocacy for the individual.

Targeted case managers will continue to perform traditional duties of intake, completion of paperwork regarding eligibility, serving in the capacity of referral and resource locating, monitoring and assessment.

The planning team shall first ensure that provision of Community Specialist Services does not duplicate the provision of any other services, including Targeted Case Management provided outside the scope of the waiver. The community specialist will frequently be involved for only a short time (30 to 60 days) and designed not to duplicate case management services. If the waiver recipient or family chooses to have the Community Specialist remain involved for a longer period of time, it must be agreed upon by the team and extended on the waiver recipient's approved plan of care. The need to extend Community Specialist Services must be fully justified in writing by the case manager. Community Specialist Services are limited to a 90-day period per waiver recipient per waiver year. Community Specialist Services may be self-directed for waiver recipients who self-direct Personal Care Services. The Community Specialist will inform and consult, intervene, and trouble shoot any problems the waiver recipient may have with self-directing their services.

A unit of service is defined as 15 minutes.

Crisis Intervention Services (H2011–UD - LHW) (H2011-UC - ID)

Crisis Invention Services provide immediate therapeutic intervention, available to a waiver recipient on a 24-hour basis, to address personal, social, and/or behavioral problems which otherwise are likely to threaten the health and safety of the waiver recipient's removal from his current living arrangement.

When need for Crisis Invention Service arises, the service will be added to the waiver recipient's approved plan of care. A separate crisis intervention plan will be developed to define in detail the activities and supports that will be provided. All Crisis Intervention Services shall be approved by the Regional Community Service Office of the DMH prior to the service being initiated.

Crisis Intervention Services will not count against the $25,000 per waiver recipient per waiver year cap in the waivers, since the need for the service cannot accurately be predicted and planned for ahead of time.

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A unit of service is defined as 15 minutes.

Transitional Assistance Service (T2038/Modifier TF UB- ACT)

Transitional Assistance Services consists of the following items, when appropriate and necessary for the participant's discharge from a nursing facility and safe transition to the community:

1. Security deposits that are required to obtain a lease on an apartment or home;
2. Essential household furnishings and moving expense required to occupy and use a community domicile, including: furniture, window coverings, food preparation items, and bed/bath linens;
3. Set-up fees or deposits for utility or services access, including telephone, electricity, heating and water;
4. Household services necessary for the individual's health and safety, such as pest eradication and one-time cleaning prior to occupancy.

Transitional Assistance Service cannot exceed $3,500.

Pest Control Service (S5121/Modifier UA– E&D) (S5121/Modifier UB - SAIL) (S5121/Modifier TF UB- ACT) (S5121/Modifier U5- TA)

Pest Control Service is the chemical eradication of pests by a professional in a waiver participant's primary residence, the presence of which may limit or prevent the service providers from entering the setting to deliver other critical waiver services.

Pest control services may be provided in a waiver participant's primary residence, which is limited to

a) A participant living in his/her own private house or apartment and who is responsible for his/her own rent or mortgage; or
b) A participant living with a primary caregiver.

Pest Control Services include the following activities:

a) Assessment or inspection
b) Application of chemical-based pesticide
c) Follow up visit

Pest control services is limited to one series of treatments per lifetime by a licensed and certified pest control company and excludes lodging during the chemical eradication process, all associated preparatory housework, and the replacement of household items. Additional treatments may be approved if the lack of such treatments would jeopardize the participant's ability to live in the community. If additional treatments are needed, the State will evaluate that participant's living situation to determine if the community arrangement is appropriate and supports their health and safety. Limits on Pest Control Services are $3,500 per waiver participant.

Individual Directed Goods and Services (T1999/Modifier UD – LHW) (T1999/Modifier UC – ID) (CWP T1999)

Individual Directed Goods and Services are services, equipment or supplies not otherwise provided through this waiver or through the Medicaid State Plan that address an identified need in the service plan (including improving and maintaining the waiver recipient's opportunities for full membership in the

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community and meet the following requirements: the item or service would decrease the need for other Medicaid services; and/or promote inclusion in the community; and/or increase the waiver recipient's safety in the home environment; the item or service is not illegal or otherwise prohibited by Federal and State statutes and regulations, and the waiver recipient does not have the funds to purchase the item or service or the item or service is not available through another source.

The limit on the amount is determined individually based on the balance of the waiver recipient's saving account at the time of the request which is maintained by the Financial Management Service Agency, but not to exceed $10,000 annually.

A unit of service is an item.

Benefits and Career Counseling Services (H2014/Modifier UD – LHW) (H2014/Modifier UC – ID)

Benefits and Career Counseling Services comprise two distinct services: Benefits Reporting Assistance (BRA) and Benefits Counseling.

The BRA is designed to assist waiver recipients and their families to understand general information on how SSI/SSDI benefits are affected by employment. Once the waiver recipient enters employment, the BRA will be available to answer questions, assist in the execution of the work incentive plan, and assist with the submission of income statement and/or Impairment Related Work Expenses to SSA as required to the extent needed as indicated by the waiver recipient.

The Benefits Counseling Services are a more intensive service provided by a Community Work Incentives Coordinator (CWIC) who will provide intensive individualized benefits counseling, benefits analysis, develop a work incentive plan and ongoing benefits planning for a waiver recipient changing jobs or for career advancement. The CWIC will work in conjunction with the BRA to develop trainings and education as needed.

The Benefits Counselor must be a Certified Work Incentives Counselor (CWIC) through a recognized training by the Social Security Administration for delivery of Career Counseling Services. This may include a level 5 security clearance from the Social Security Administration/Department of Homeland Security due to Personally Identifiable Information.

Community Experience Services (H2021/Modifier UD – LHW) (H2021/Modifier UC – ID) (H2021/ Modifier UD/SE – LHW) (H2021/Modifier UC/SE – ID)

Community Experience Services has two distinct categories: Individual and Group Community Experience Services. Community Experience Services are non-work-related activities that are customized to the waiver recipient (s) desires to access and experience community participation. Community Experience Services are provided outside of the waiver recipient's residence and can be provided during the day, evening, or weekends. The intent of Community Experience Services is to engage in activities that will allow the waiver recipient to either acquire new adaptive skills or support the waiver recipient in utilizing adaptive skills in order to become actively involved in their community.

Community Experience Individual Services are provided to a waiver recipient, with a one-to-one staff to participant ratio which is determined necessary

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through functional and health risk assessments prior to approval. Additionally, a behavioral assessment will need to support this specialized staffing if related to behavioral challenges prior to approval.

Community Experience Group Services are provided to groups of waiver recipients, with a staff to waiver recipient ratio of one to two or more, but no greater than four (4) waiver recipients.

A unit of service is defined as 15 minutes.

Housing Stabilization Services (T2025/Modifier UC – ID) (T2025/Modifier UD – LHW)

The Housing Stabilization Service enables waiver recipients to maintain their own housing as set forth in the waiver recipient's approved plan of care (POC). Housing Stabilization Services must be provided in the home or a community setting. Housing Stabilization Service includes the following components:

1. Conducting a Housing Coordination and Stabilization Assessment identifying the waiver recipient's preferences related to housing and needs for support to maintain housing, budgeting for housing/living expenses, obtaining/accessing sources of income necessary for rent, home management, establishing credit and understanding and meeting obligations of tenancy as defined in lease terms.
2. Assisting waiver recipient with finding and securing housing as needed. This may include arranging or providing transportation.
3. Assisting waiver recipient in securing supporting documents/records, completing/submitting applications, securing deposits, and locating furnishings.
4. Developing an individual housing stabilization plan based upon the Housing Coordination and Stabilization Assessment as part of the overall Person-Centered Plan.
5. Participating in Person-Centered plan meetings at redetermination and/or revision plan meetings as needed.
6. Providing supports and interventions per the Person-Centered Plan (individualized housing stabilization portion).
7. Communication with the landlord and/or property manager regarding the waiver recipient's disability (if authorized and appropriate), detailing accommodations needed, and addressing components of emergency procedures involving the landlord and/or property manager.
8. If at any time the waiver recipient's housing is placed at risk (i.e., eviction, loss of roommate or loss of income), Housing Stabilization Services will provide supports to retain housing or locate and secure new housing or sources of income to continue community based supports which includes locating new housing, sources of income. etc.

A unit of service is defined as 15 minutes.

Assistance in Community Integration Services (T2025/Modifier UD – LHW)

The Assistance in Community Integration Service enables waiver recipients to maintain their own housing as set forth in the waiver recipient's approved plan

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of care (POC). Assistance in Community Integration Services must be provided in the home or a community setting. The Assistance in Community Integration Service includes the following components:

1. Conducting a community integration assessment identifying the waiver recipient's preferences related to housing and needs for support to maintain community integration.
2. Assisting waiver recipient's with finding and securing housing as needed. This may include arranging for or providing transportation.
3. Assisting waiver recipient in securing supporting documents/records, completing/submitting applicants, securing deposits, and locating furnishings.
4. Developing an individualized community integration plan based upon the assessment as part of the overall Person-Centered Plan. Identify and establish short and long-term measurable goal(s) and establish how goals will be achieved and how concerns will be addressed.
5. Participating in Person-Centered plan meetings at re-determination and/or revision plan meetings as needed.
6. Providing supports and interventions per the Person-Centered Plan (individualized community integration portion). Identify any additional supports or services needed outside the scope of Community Integration services and address among the team.
7. Supports to assist the waiver recipient in communicating with the landlord and/or property manager regarding the waiver recipient's disability (if authorized and appropriate), detailing accommodations needed, and addressing components of emergency procedures involving the landlord and/or property manager.
8. Assistance in Community Integration will provide supports to preserve the most independent living arrangement and/or assist the waiver recipient in locating the most integrated option appropriate to the waiver recipient.

A unit of service is defined as 15 minutes.

Personal Emergency Response System Services (PERS) (S5160Modifier UD – LAH) (S5160Modifier UC – ID) (S5160Modifier UD/HW – LAH) (S5160Modifier UC/HW – ID) (S5161Modifier UD – LAH) (S5161Modifier UC – ID) (S5161Modifier UD/HW – LAH) (S5161Modifier UC/HW – ID)

Personal Emergency Response System (PERS) Services provides a direct telephonic or other electronic communications link between waiver recipients and health professionals to secure immediate assistance in the event of a physical, emotional or environmental emergency. PERS may also include cellular telephone service used when a conventional PERS is less cost-effective or is not feasible. PERS may include installation, monthly fee (if applicable), upkeep and maintenance of devices or systems as appropriate.

The use of PERS requires assurance that safeguards are in place to protect privacy, provide informed consent, and that documented needs are addressed in the least restrictive manner. The waiver recipient's Person-Centered Plan should identify options available to meet the need of the waiver recipient in terms of preference while also ensuring health, safety, and welfare.

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PERS can be directed by waiver recipients or family but must adhere to all the traditional service rules.

PERS will not be authorized for waiver recipients receiving Residential Habilitation Training Services. PERS will not replace supervision and monitoring of activities of daily living which are provided to meet requirements of another service (e.g., Personal Care Services; Day Habilitation Services).

Emergency Response System installation and testing is approximated to cost $500.00; Emergency Response Monthly Service Fee (excludes installation and testing) is approximated to cost no more than $83.00/month; Emergency Response system purchase is approximated to cost $1,500.00. The maximum cost for all PERS per year is $3,000.00.

Supported Employment Transportation Services (S0215Modifier UD – LAH) (S0215Modifier UC – ID)

Supported Employment Transportation Services permit waiver recipients access to and from their place of employment in the event that the support team is unable to facilitate transportation through other means. Supported Employment Transportation Services must be necessary to support the waiver recipient in work related travel and cannot be reimbursed for merely transportation.

Transportation must be provided by public carriers (e.g., charter bus or metro transit bus) or private carriers (e.g., Taxicab). The waiver recipient may use a commercial transportation agency.

Remote Supports Services (T1028/Modifier UC – ID) (T1028/Modifier UD – LHW) (T2033/Modifier UC – ID) (T2033/Modifier UD – LHW)

Remote Supports Services are intended to address a person's assessed needs in his/her residence and are to be provided in a manner that promotes autonomy, minimizes dependence on paid support staff, and reduces the need for in-person services that may be more intrusive.

Remote Supports Services are services provided to recipients who are 18 years of age or older, at their place of residence, by Remote Support staff housed at a remote location and who are engaged with the recipient through equipment with the capability for live, two-way communication.

Remote Supports Services shall be provided in real time, not via a recording, by awake staff at a remote monitoring base using an appropriate, stable, and reliable electronic connection.

Equipment used to meet this requirement may include but is not limited to one or more of the following components:

- Sensor Based System (e.g. motion sensors, doors, windows, personal pagers, smoke detectors, bed sensors etc.)
- Radio frequency identification;
- Live video feed;
- Live audio feed;
- Web-based monitoring system;
- Another device that facilitates live two-way communication;
- Contact ID

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Financial Literacy and Work Incentive Benefits Counseling Services CWP

(Work Incentive Benefits Counseling (CWP/H2014/Modifier/SE); (Financial Literacy Counseling (CWP/H2014)

For a waiver participant living at home with the family who is providing a home and/or natural care or support for the waiver participant, the Financial Literacy component of this service is designed to:

- Support continuity of stable housing, community tenure, and natural supports for the waiver participant by supporting the person in sustaining and improving his/her economic self-sufficiency.
- Enable improvement of waiver participant's economic self-sufficiency necessary to sustain his/her living situation including availability of natural supports for that living situation.
- Assist with evaluating a waiver participant's financial health and current level of financial literacy and making a plan with specific strategies to improve financial health and increase the waiver participant's level of financial literacy.
- Teach financial literacy skills.
- Assist with access to community resources available to address improvement of economic self-sufficiency and financial health, including ability to sustain current living arrangement.

For a waiver participant living at home with the family who is providing a home and/or natural care or support for the waiver participant, the Work Incentive Benefits Counseling is designed to:

- Provide general introductory education that identifies and explains the multiple pathways to ensuring individualized integrated competitive employment results in increased economic self-sufficiency (net financial benefit) through the use of various work incentives. This general introductory education should also repudiate myths and alleviate fears and concerns related to seeking and working in individualized integrated competitive employment. Provide a thorough Work Incentive Benefits Analysis addressing the benefits, entitlements, subsidies and services the individual receives to assess the impact that income from employment may have on continued eligibility and benefit amounts, including health coverage. Individuals are informed of work incentives, provisions that are designed to help protect benefits while working (i.e. Impairment Related Work Expense, Earned Income Exclusion, Plan for Achieving Self Support (PASS), Continued Medicaid and Extended Medicare, as well as other benefit programs for which the individual may be eligible. The information is intended to assist the person in making informed decisions about how much they can work and earn through individualized integrated competitive employment.
- Introductory general education as part of Work Incentive Benefits Counseling shall be limited to individuals ages 16-60 who are not currently employed in individualized, integrated competitive employment and shall be limited to a total of four (4) hours of face-to-face service. This component of service can be reauthorized once per waiver year.
- Work Incentive Benefits Analysis, as part of Work Incentive Benefits Counseling, shall be limited to individuals ages 16-60 who are not currently employed in individualized, integrated competitive employment and shall be limited to a total of twenty-three (23) hours of service

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covering all necessary steps for production of a Work Incentive Benefits Analysis report.

- The service must be provided in a manner that supports the person's communication style and needs, including, but not limited to, age-appropriate communications, translation and/or interpretation services for persons of limited English-proficiency or who have other communication needs requiring translation including sign language interpretation, and ability to communicate with a person who uses an assistive communication device.
- This service may not be provided if the person receives any form of work benefits counseling from any other source or waiver service (i.e., Supported Employment).

A unit is defined as item or 15 minutes.

Minor Home Modifications Services CWP (Minor Home Modifications (CWP S5165) (S5165/Modifier UA – E&D) (S5165/Modifier TF UB –ACT)

Home Modifications are alterations to the home, required by the individual PCP, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home. Modifications include:

Provision and installation of certain home mobility aids, including:

- A wheelchair ramp and modifications directly related to and specifically required for the construction or installation of the ramp
- Handrails for interior or exterior stairs or steps
- Grab bars and other devices

Minor physical adaptations to the interior of the individual's place of residence which are necessary to ensure the health, welfare and safety of the individual, or which increase the member's mobility and accessibility within the residence, including:

- Widening of doorways
- Modifications of bathroom facilities
- Installation of electric and plumbing systems necessary to accommodate any medical equipment/supplies needed for the welfare of the individual

All services shall be provided in accordance with applicable state or local building codes.

A unit is defined as job.

For the E&D Waiver, limits on Home Modifications are $5,000 per recipient per lifetime. Any expenditure in excess of $5,000 must be approved by the Operating Agency. This item requires prior authorization by the Operating Agency. Home Modifications are excluded from rental properties unless a temporary modification such as a modular ramp is needed and there is documentation that the modification is approved by the landlord. A unit is defined as an item.

For the ACT Waiver, this service may be necessary to assist an individual to transition from an institution to a home and community-based Waiver. Additionally, this service is used to maintain a participant in the community once transitioned. For the ACT Waiver, the limits on Home Modifications are $5,000 per recipient per lifetime. Any expenditure in excess of $5,000 must be approved by the ACT Waiver Coordinator and the Medicaid Agency designated personnel. The service should not be billed until the first day the

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participant is transitioned and has begun to receive waiver services in order to qualify as Waiver funds. If the individual fails to transition to the ACT Waiver, reimbursement will be at the administrative rate.

For the ACT and E&D Waivers, any construction/installation must be completed in accordance with state and local building code requirements, American with Disabilities Act Accessibility Guidelines (ADAAG) and by a licensed contractor.

Community Integrations Connections and Skills Training Services

(Community Integration Connections and Skills Training CWP 1:2 (CWP H2021/Modifier HO); (Self-directed Community Integration Connections and Skills Training – CWP 1:2 (CWP H2021/Modifier HN/HW); (Community Integration Connections and skills training – CWP1:1 (CWP H2021/Modifier HN); (Self-directed Community Integration Connections and Skills CWP 1:1 (CWP H2021/Modifier HO/HW); (Community Integration Connections and Skills Training CWP 1:3 (CWP H2021/Modifier HP); (Self-Directed Community Connections and Skills Training CWP 1:3 (CWP H2021/Modifier HP/HW)

Time-limited services which identify and arrange integrated opportunities for the person to achieve his/her unique goals for community participation, involvement, membership, contribution and connections, including targeted education and training for specific skill development to enable the waiver participant to develop ability to independently (or with natural supports only) engage in these integrated opportunities as specified in the person's Person-Centered Plan.

This service focuses specifically on successful participation in community opportunities that offer the opportunity for meaningful, ongoing interactions with members of the broader community. This service also focuses on ensuring the ongoing interactions with members of the broader community are meaningful and positive, leading to the development of a broader network of natural supports for the individual. The community connections component of this service is focused on assisting the person to find and become engaged in specific opportunities for community participation, involvement, membership, contribution and connections.

This service shall be provided in a variety of integrated community settings that offer opportunities for the person to achieve their personally identified goals for community participation, involvement, membership, contribution and connections, including developing and sustaining a network of positive natural supports.

The skills training component of this service is instructional and training-oriented, and not intended to provide substitute task performance by staff. Skill training is focused on the development of skills identified in the Person-Centered Plan that will enable the person to continue participation in integrated community opportunities without waiver-funded supports.

A unit is defined as 15 minutes.

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Community Transportation Services – CWP

(Community Transportation – Agency Paid Driver WITH RESIDENTIAL SERVICE (CWP T2001/Modifier HE); (Community Transportation – Agency Paid Driver NO RESIDENTIAL SERVICE (CWP T2001/Modifier SE); (Community Transportation – Agency Volunteer Driver WITH RESIDENTIAL SERVICE (CWP T2001/Modifier HI); (Self-Directed Community Transportation – With CIE (CWP T2001/Modifier HW/SE); (Self-Directed Community Transportation (CWP T2001/Modifier HW)

Transportation services offered in order to enable an individual to access the broader community, including competitive integrated workplaces, opportunities for integrated community participation, involvement and contribution, and community services, resources and businesses, for purposes specified in the Person-Centered Plan. These services allow people to engage in typical day-to-day (non-medical) integrated community opportunities and activities such as going to and from paid, competitive, integrated employment, stores, bank, social opportunities with other members of the broader community, social events, clubs and associations, other community activities, and attending a worship service when public or other community-based transportation services or transportation provided by natural supports are not available. As part of the service, a natural or paid support-giver may accompany the person using Community Transportation, if the need for such supports are necessary and documented in the Person-Centered Plan.

A unit is defined as mile and/or month.

Natural Support or Caregiver Education and Training Services

(Natural Support or Caregiver Education and Training (CWP T2012); (Natural Support or Caregiver Education and Training Self-Directed (CWP T2012/Modifier HW)

This service provides a natural, unpaid support or natural, unpaid caregiver of a waiver participant with education, training and technical assistance, as needed, to enable the natural support or natural caregiver to effectively provide supports to the waiver participant as documented in the person-centered plan.

A unit is defined as cost.

PEER Specialist Services – CWP (PEER Specialist (CWP T2013)

A service that assists a person to develop and utilize skills and knowledge for self-determination in one or more of the following areas: Directing the person-centered planning (PCP) process; Understanding and considering self-direction; Understanding and considering individualized integrated employment/self-employment; Understanding and considering independent and supported living community living options. The service is provided on a time-limited basis, determined by the person's individual need, by a peer with intellectual or developmental disabilities who has experience matched to the focus areas, needs and goals of the person receiving this service: has successfully directed their own Person-Centered Planning process; has self-directed their own services; has successfully obtained individualized integrated employment at a competitive wage; and/or utilizes independent/supported living options.

A unit is defined as 15 minutes.

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Integrated Employment Path Services– CWP

(Integrated Employment Path Services – 1:1 (CWP T2015); (Integrated Employment Path Services – 1:2 (CWP T2015/Modifier HW); (Integrated Employment Path Services – 1:8 (CWP T2015/Modifier HO)

The provision of time-limited learning and work experiences, including volunteering opportunities, where a person can develop general, non-job-task-specific strengths and skills that contribute to employability in individualized integrated employment or self-employment. Services are expected to specifically involve strategies that facilitate a participant's successful transition to individualized integrated employment or self-employment. Persons receiving Integrated Employment Path Services must have a desire to obtain some type of individualized integrated employment or self-employment and this goal must be documented in the PCP as the goal that Integrated Employment Path Services are specifically authorized to address.

Services should be customized to provide opportunities for increased knowledge, skills and experiences specifically relevant to the person's specific individualized integrated employment and/or self-employment goals and career goals. If such specific goals are not known, this service can also be used to assist a person to identifying his/her specific individualized integrated employment and/or self-employment goals and career goals.

This service is limited to no more than one year. One extension of up to one year can be allowed only if the person is actively pursuing individualized integrated employment or self-employment in an integrated setting and has documentation that a service(s) (i.e. ADRS Individualized Plan for Employment in place or Job Development or Self-Employment Start-Up funded by the Waiver) is concurrently authorized for this purpose. The one-year extension may be repeated only if a person loses individualized integrated employment or self-employment and is seeking replacement opportunities.

A unit is defined as 15 minutes.

Community Based Residential Services – (Community based Residential Service (CWP T2016/Modifier SE)

Community-Based Residential Services enable an individual to avoid institutionalization and live in a community setting that provides services to support the person's maximum independence, autonomy and full integration in their community, ensure each person's rights and abilities to make choices and support each person in a manner that complies fully with HCBS Settings Rule standards, including standards for provider-owned or controlled homes. Community-Based Residential Services are provided for up to four individuals in a dwelling which may be rented, leased, or owned by the provider. The person has the right to a legally enforceable lease or rental agreement with the provider that offers the same appeal rights and eviction protections as is required under state landlord-tenant law.

This service offers individualized services and supports that enable the person supported to acquire, retain, and improve skills necessary to reside in the least restrictive residential setting possible. The setting in which the service is provided must be an ADMH-certified, community-based residential setting which supports each person's independence and full integration into

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the community and ensures each person's basic needs (e.g., food, clothing, etc.), choice, rights, safety and security. Community-Based Residential Services provide care, supervision, and skills training in activities of daily living, home management and community integration.

A unit is defined as day.

Adult Family Home Services CWP – (Adult Family Home (CWP T2016)

A community-based alternative to residential habilitation service that enables up to three persons receiving this service to live in the home of trained host family caregivers (other than the person's own family) in an adult foster care arrangement. In this type of shared living arrangement, the person(s) moves into the host family's home, enabling the person(s) to become part of the family, sharing in the experiences of a family, while the trained family members provide the individualized services that: support each person's independence and full integration in their community, ensure each person's choice and rights and support each person in a manner that complies fully with HCBS Settings Rule standards, including standards for provider-owned or controlled homes.

A unit is defined as day.

Independent Living Skills Training Services CWP

(Independent Living Skills Training (CWP T2021); (Independent Living skills Training Self-directed (CWP T2021/Modifier/HW);

Time-limited, focused service that provides targeted education and training for specific skill development to enable the waiver participant to develop ability to independently perform routine daily activities at home as specified in the person's Person-Centered Plan. Services are not intended to provide substitute task performance by staff. Services are instructional and training-oriented, focused on development of skills identified in the Person-Centered Plan. Independent Living Skills Training is intended as a short-term service designed to allow a person to acquire specific skills for independence in defined tasks and activities for community living. Goals for skill development and independence at home must be age-appropriate for the waiver participant while recognizing that learning skills for maximizing individual initiative, autonomy and independence at home should start at a very young age.

A unit is defined as 15 minutes.

Housing Start-Up Assistance Services – CWP

(Housing Start-Up Assistance – cost other than Direct Service by Waiver Provider (CWP T2025/Modifier/HE); (Housing Start-Up Assistance – Direct Service by Waiver Provider (CWP T2038)

A service intended to provide essential services and items needed to establish an integrated community living arrangement for persons relocating from an institution or a provider owned or controlled residential setting to one where the individual is directly responsible for his/her own living expenses. Housing Start-Up Assistance is intended to enable the person to establish an independent or supported living arrangement. Housing Start-Up Assistance may also include person-specific services and supports that may be arranged, scheduled, contracted or purchased, which support the person's

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successful transition to a safe, accessible independent or supported living situation. No institutional length of stay requirement exists to access this service.

A unit is defined as item or 15 minutes.

Housing Counseling – CWP (Housing Counseling (CWP T2025)

Services that provide assistance to a person when acquiring housing in the community, where ownership or rental of housing is separate from service provision. The purpose of Housing Counseling Services is to promote consumer choice and control of housing and access to housing that is affordable, accessible to the extent needed by the individual, and promotes community inclusion. Housing Counseling Services include counseling and assistance to the individual, based on individual needs and a plan reflecting the needs.

A unit is defined as 15 minutes.

Family Empowerment and Systems Navigation Counseling Services – CWP (Family Empowerment and Systems Navigation Counseling (CWP T2025/Modifier HO)

Family Empowerment and Systems Navigation Counseling matches the involved family members (e.g. support/care givers; legal guardians) of an individual with intellectual disabilities with a local professional or similar reputable adult with broad knowledge of the variety of programs and local community resources that are available to an individual with intellectual disabilities and his/her family. The Family Empowerment Counseling and Systems Navigation Service is intended to be a time-limited service that involves assessment of the individual's situation (including needs, goals), assessment of the family's specific goals and needs for information, assistance, and referral to address the individual and family's situation.

The service further includes, researching as needed, and sharing of the identified information, connecting the family with assistance, and making referrals as appropriate. The goal of the service is to empower the family with the information, connections and referrals they need, and to work with the family to increase their skills in problem-solving and leveraging available programs and community resources, including Support Coordination. This service is also intended, through temporary peer supervision, to facilitate an opportunity for interested family members, who have received this service, to become providers of this service themselves to grow the network of providers of this service over time.

A unit is defined as 15 minutes.

Supported Living Service – CWP

(Supported Living Service: Non-intensive (CWP T2032); (Supported Living Service: Intensive (CWP T2032/Modifier/SE)

Services that include training and assistance in maintaining a home of one's own: a residence not owned or controlled by a waiver service provider or a residence that is not the home of a family caregiver. The home may be shared with other freely chosen housemates who may or may not also receive waiver services and/or have a disability. Supported Living Services

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are provided with the goal of maximizing the person's independence and interdependence with housemates and natural supports, using a combination of teaching, training, technology and facilitation of natural supports. Supported Living Services are delivered according to the person's Supported Living Service Plan. This service is intended for persons who, with technology, natural supports and good advanced planning, need intermittent and/or on-call staff support to remain in their own home and who do not need and will not benefit from around-the-clock staffing. Supported Living Services are differentiated from Personal Assistance by virtue of the 24-hour on-call access to supports on an as-needed/emergency basis that are part of Supported Living Services.

A unit is defined as day.

Supervisory Visit Services – E&D

(Supervisory Visit Services: (E&D T1001/Modifier/UA- E&D)

Supervisory Visit Services are provided by a Waiver Direct Service Provider (DSP) in the supervision or Personal Care, Homemaker, Unskilled Respite and Companion workers. Supervisory Visit Services shall be conducted by Alabama Licensed Registered Nurses (RN) or Alabama Licensed Practical Nurses (LPN) to monitor DSP staff performance to ensure adherence of Waiver guidelines, quality of service provision to Waiver recipients, and recipient satisfaction with service provision. The RN and LPN must meet all federal and state requirements to provide services to eligible Medicaid recipients under Waiver authority. State Plan EPSDT services must be exhausted prior to any use of Waiver services for individuals under the age of 21.

Supervisory Visits shall be billed in 15 minutes increments (not to exceed 60 minutes) every 60 days or 4 increments (not to exceed 60 minutes) every 60 days. No reimbursement will be made for attempted or missed visits.

One increment is defined as 15 minutes.

107.2.5 Characteristics of Persons Requiring ICF-IID Level of Care Through the ID Waiver (formerly MR Waiver) and Living at Home Waiver

Services provided in an intermediate care facility for individuals with intellectual disabilities in Alabama are those services that provide a setting appropriate for a functionally individual with intellectual disabilities in the least restrictive productive environment currently available.

Generally, persons eligible for the ICF-IID level of care provided through the ID, CWP, and LHW 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

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ICF-IID-care requires the skills of a QIDP to provide directly or supervise others in the provision of services. ICF-IID services address the functional deficiencies of the beneficiary to allow the beneficiary to experience personal hygiene, participate in daily living activities appropriate to his functioning level, take medication under appropriate supervision (if needed), receive therapy, receive training toward more independent functioning, and experience stabilization as a result of being in the least restrictive, productive environment that promotes the individual's developmental process.

Determining Eligibility for ID, CWP, and LHW Waiver

Determination regarding eligibility for care under the ID, CWP, & LHW Waiver is made by a Qualified Intellectual Disabilities Professional (QIDP). An interdisciplinary team (described below) recommends continued stay. The recommendation is certified by a (QIDP) 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 intellectual 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 intellectual 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 intellectual 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

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Individual Assessments

Medicaid requires an individual plan of care for each ID, CWP & LHW waiver service recipient. The Individual Habilitation Plan (IHP) is subject to review by Medicaid and CMS.

The DMH (or its contract service providers) uses assessment procedures to screen recipients for eligibility for the Waiver services as an alternative to institutionalization. Assessment procedures are based on eligibility criteria for ICF-IID developed jointly by DMH and Medicaid.

Review for "medical assistance" eligibility may be performed by a qualified practitioner in the DMH, by its contract service providers, or by qualified (Diagnostic and Evaluation Team) personnel of the individual or agency arranging the service.

Recipients are re-evaluated on an annual basis. Written documentation of all assessments is maintained in the recipient's case file and is subject to review by Medicaid and CMS.

A written assessment is a method for determining a recipient's current long-term care needs. This comprehensive instrument is used to access each individual recipient's functional, medical, social, environmental, and behavioral status. Information obtained should be adequate enough to make a level of care decision and for case managers to develop an initial plan of care.

Re-evaluations are done on an annual basis or when needed. Written documentation of all assessments is maintained in the recipient's case file and is subject to review by Medicaid and CMS.

107.2.6 Informing Beneficiaries of Choice

Medicaid is responsible for ensuring that beneficiaries of the waiver service program are advised of feasible service alternatives and receive a choice regarding which type of service they wish to receive (institutional or home- and/or community-based services).

Medicaid advises applicants for NF, ICF, ICF-IID services, or their designated responsible party, of feasible alternatives to institutionalization at the time of their entry into the waiver system. All applicants found eligible will be offered the alternative unless there is reasonable expectation that the services required would cost more than institutional care.

When residents of long-term care facilities become eligible for home and community-based services under this waiver, the resident will be advised of the available services and given a choice of service providers.

107.2.7 Cost for Services

The costs for services to individuals who qualify for home and community-based care under the waiver program will not exceed, on an average per capita basis, the total expenditures that would be incurred for such individuals if home and community-based services were not available.

The cost for services to individuals who qualify for home and community-based care under the LHW waiver program will not exceed a cap of $25,000 per client per year with the exception that crisis intervention services are not included in the cap.

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107.2.8 Records Used for Medicaid Audits

Providers must maintain financial accountability for funds expended on HCBS and provide a clearly defined audit trail.

Providers must retain records that fully disclose the extent and cost of services provided to eligible recipients for a three-year period. These records must be accessible to the Alabama Medicaid Agency and appropriate state and federal officials. If these records are not available within the state of Alabama, the provider will pay the travel cost of the auditors.

The state agencies as specified in the approved waiver document as operating agencies of home and community-based services will have their records audited at least annually at the discretion of the Alabama Medicaid Agency. Payments for services are adjusted to actual cost at the end of each waiver year.

The Alabama Medicaid Agency will review at least annually the recipient's care plans and services rendered by a sampling procedure. The review will include appropriateness of care and proper billing procedures.

The state agencies as specified in the approved waiver document provide documentation of actual costs of services and administration. The quarterly cost report includes all actual costs incurred by the operating agency for the previous quarter and includes costs incurred for the current year-to-date. The state agencies submit this document to Medicaid before the first day of the third month of the next quarter.

Failure to submit the actual cost documentation can result in the Alabama Medicaid Agency deferring payment until this documentation has been received and reviewed.

The providers of the HCBS waivers will have their records audited at least annually at the discretion of Medicaid. Medicaid will recover payments that exceed actual allowable cost.

Medicaid reviews recipients' habilitation and care plans and services rendered by a sampling procedure. The review includes appropriateness of care and proper billing procedures.

Providers of the E&D and SAIL HCBS waivers are required to file a complete uniform cost report of actual statistics and costs incurred during the entire preceding year. The cost reports for E&D and SAIL must be received by Medicaid on or before December 31. Extension may be granted only upon written request. Failure to submit the actual cost documentation may result in the AMA deferring payment until this documentation has been received and reviewed.

Providers of the LHW, TA Waiver for Adults, ID, CWP, and ACT Waivers are not required to submit uniform cost reports. The method of payment is on a fee-for-service basis.

Quarters for E&D and SAIL 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

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107.2.9 HCBS Payment Procedures

Each covered HCB waiver service is identified on a claim by a procedure code. Respite care will have one code for skilled and another for unskilled.

The basis for the fees is usually based on audited past performance with consideration given to the health care index and renegotiated contracts. The interim fees may also be changed if a provider can show that an unavoidable event(s) has caused a substantial increase or decrease in the provider's cost.

For each recipient, the claim will allow span billing for a period up to one month. There may be multiple claims in a month; however, no single claim can cover services performed in different months. For example, 10/15/02 to 11/15/02 would not be allowed. If the submitted claim covers dates of service part or all of which were covered in a previously paid claim, the claim will be rejected.

Payment will be based on the number of units of service reported on the claim for each procedure code.

Accounting for actual cost and units of services provided during a waiver year must be captured on CMS Form 372. The following accounting definitions will be used to capture reporting data, and the audited figures used in establishing new interim fees:

- A waiver year consists of twelve consecutive months starting with the approval date specified in the approved waiver document.
- An expenditure occurs when cash or its equivalent is paid in a quarter by a state agency for waiver benefits. For a public/governmental provider, the expenditure is made whenever it is paid or recorded, whichever is earlier. Non-cash payments, such as depreciation, occur when transactions are recorded by the state agency.
- The services provided by an operating agency is reported and paid by dates of service. Thus, all services provided during the twelve months of the waiver year will be attributed to that year.

The provider's costs shall be divided between benefit and administrative cost. The benefit portion is included in the fee for service. The administrative portion will be divided in twelve equal amounts and will be invoiced by the provider directly to the Alabama Medicaid Agency. Since Administration is relatively fixed, it will not be a rate per claim, but a set monthly payment. As each waiver is audited, this cost, like the benefit cost, will be determined and lump sum settlement will be made to adjust that year's payments to actual cost.

The Alabama Medicaid Agency's Provider Audit/Reimbursement Division maintains the year-end cost reports submitted by the Alabama Department of Senior Services (ADSS).

Providers must retain records that fully disclose the extent and cost of services provided to the eligible recipients for a five (5) year period. These records must be accessible to the Alabama Medicaid Agency and appropriate state and federal officials.

There must be a clear differentiation between waiver services and non-waiver services. There must be a clear audit trail from the point a service is provided

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through billing and reimbursement. The OA, Alabama Medicaid Agency and Centers for Medicare and Medicaid Services (CMS) must be able to review the Plan of Care to verify the exact service and number of units provided, the date the service was rendered, and the direct service provider for each recipient. There must be a detailed explanation of how waiver services are segregated from ineligible waiver costs.

NOTE:

The rates for each service for each operating agency may differ. For the E&D and SAIL waiver, operating agencies have 120 days from the end of a waiver year to file their claims. Since the actual cost incurred by the operating agency sets a ceiling on the amount it can receive, no claims for the dates of service within that year will be processed after the adjustment is made. For the LHW, ID, CWP, and ACT Waivers, the operating agency must file all claims for services within 12 months from the date of service. For the TA Waiver for Adults, the providers must file all claims for services rendered within 12 months from the date of service provision.

107.2.10 Records for Quality Assurance Audits

The operating agencies for the E&D, ID, LHW, CWP, and ACT waivers are required to maintain all records pertaining to the waiver recipients. They should also maintain the following information for audit purposes:

- Daily activity logs
- Narratives
- Evaluations and reevaluations
- Complaints and grievances
- Billing and payment records
- Plan of Care
- Delivery of services
- Any other important tools used to determine the success of the waiver services

This information is used to ensure that the state is in accordance with the approved waiver document and services are appropriate for the individual being served.

This information shall be made available to Medicaid and any other party in the contractual agreement at no cost.

NOTE:

Records for Quality Assurance audits for the TA Waiver for Adults conducted by the in-house Medicaid reviewer will be maintained at the Alabama Medicaid Agency.

107.2.11 Appeal Procedure (Fiscal Audit)

Medicaid conducts fiscal audits of all services. At the completion of a field audit there will be an exit conference with the provider to explain the audit

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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 Alabama Coordinated Health Network (ACHN), refer to Chapter 40 to determine whether your services require a referral from the Primary Medical Provider (PMP).

Application Process

The case manager receives referrals from hospitals, nursing homes, physicians, the community, and others for persons who may be eligible for HCBS.

The plan of care, which is developed by the case manager and applicant's physician, is part of this assessment. The plan of care includes the following:

- Objectives
- Services
- Provider of services
- Frequency of services

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The Alabama Medicaid Agency requires providers to submit an application in order to document dates of service provision to long term care recipients maintained by the long-term care file. Application approvals will be done automatically through systematic programming. Quality Improvement and Standards Division will perform random audits on a percentage of records to ensure that documentation exists to support the medical level of care criteria, physician certification, as well as other state and federal requirements.

Case managers and/or designated staff of the HCBS waiver Operating Agency (ies) will assess the client to determine the risk for institutionalization and determine if the medical level of care is met according to Medicaid criteria.

Assessment data will be entered and submitted electronically using the Alabama Medicaid Agency Interactive website. If problems are encountered such as mismatched Social Security Numbers and/or Medicaid numbers, date conflicts, invalid NPIs, or financial ineligibility, the auto-application will be denied and returned. Information will be provided to the user of the appropriate action(s) to take to correct the problem and will be allowed to resubmit the application.

The application, upon completion of processing, will systematically assign approval dates in one-year increments. For initial assessments, once the application is submitted with an indication of an initial assessment, the system will apply the begin date as the date of submission plus one year, which is extended to the last day of the month. For re-determinations, the application is submitted with an indication of a re-determination and the system will pick up the end date already on the file and extend for one year.

No charges for services rendered under the waiver program prior to the approval payment dates will be paid.

Application Process for TA Waiver for Adults

The Alabama Department of Senior Services (ADSS) targeted case manager will receive referrals from hospitals, nursing homes, physicians, the community and others for persons who may be eligible for home and community based services.

An assessment document will be completed by the targeted case manager, in conjunction with the applicant's physician. This document will reflect detailed information regarding social background, living conditions, and medical problems of the applicant. A copy of this document will be submitted to the Alabama Medicaid Agency for approval.

The targeted case manager, in conjunction with the applicant's physician will develop a plan of care. The plan of care will include objectives, services, provider of services, and frequency of service. The plan of care must be submitted to the Alabama Medicaid Agency for approval. Changes to the original plan of care are to be made as needed to adequately care for an individual. Reasons for changes must be documented on the client's care plan, which is subject to the review of the Alabama Medicaid Agency. The plan of care must be reviewed by the targeted case manager as often as necessary and administered in coordination with the recipient's physician.

The targeted case manager will coordinate completion of the medical need admissions form with the applicant's physician and the financial application form for submission to the Alabama Medicaid Agency’s Long Term Care Division.

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Agency will review to determine if the individual meets the criteria for nursing facility care, in accordance with Rule No 560-X-10-.10 of the Alabama Medicaid Administrative Code.

If approved, the applicant and the targeted case manager will be notified in writing.

If denied, the applicant and the targeted case manager will be notified and the reconsideration process will be explained in writing as described in Rule No. 560-X-10-.14 of the *Alabama Medicaid Administrative Code*.

When an application is approved by the Alabama Medicaid Agency, a payment date is also given for the level of care for which a recipient has been approved. No charges for services rendered under the Waiver Program prior to this approved payment date will be paid.

A current assessment document, along with a new plan of care, and medical need admission form must be submitted by the targeted case manager to the Alabama Medicaid Agency at each re-determination of eligibility which shall be at least every twelve (12) months.

HCBS Waiver Appeal Process

An individual receiving a Notice of Action (denial, termination, suspension, reduction in services) from the operating agency (OA), may request an appeal if he/she disagrees with the decision. The Notice of Action explains the reason for the denial, termination, suspension, or reduction in waiver services and the appeal rights made available to them.

Appeal requests for ACT, SAIL, E&D, & TA Waivers

If an individual chooses to appeal an adverse decision, a written request must be submitted to the contact person designated by the OA **within 30 days from the date of the notice of action.** However, services may continue until the final outcome of the hearing process, if the written request is received **within 10 days after the effective date of the action unless:**

(1) It is determined at the hearing that the sole issue is one of Federal or State law or policy; and

(2) The agency promptly informs the beneficiary in writing that services are to be terminated or reduced pending the hearing decision.

The individual will have an Informal Conference. After the Informal Conference, the Medicaid Waiver Program Administrator will send a certified letter notifying the individual of the decision. If the individual/guardian is dissatisfied with the decision, a Fair Hearing may be requested. A written request for a hearing must be received **no later than 30 days from the date of the notice of action.**

Requests made for ID, CWP, and LHW Waivers

If an individual chooses to appeal an adverse decision, a written request must be submitted to the Associate Commissioner for the Developmental Disabilities Division **no later than 15 calendar days after the effective date printed on the notice of action.** However, services may continue until the final outcome of the hearing, if the written request is received **within 10 days after the effective date of the action unless:**

(1) It is determined at the hearing that the sole issue is one of Federal or State law or policy; and

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(2) The agency promptly informs the beneficiary in writing that services are to be terminated or reduced pending the hearing decision.

Upon receipt of an appeal request by the Associate Commissioner for the Developmental Disabilities Division, contact is made with the Regional Community Services Offices to request the information packet that they reviewed to base the denial decision. The Associate Commissioner will contact the individual/guardian and inform them that the division is in the process of reviewing their information. A written decision from the Associate Commissioner is mailed (certified) to the individual/guardian within 21 days after the review of all information. If the individual/guardian disagrees with the Associate Commissioner's decision, he/she can request a Fair hearing to the AMA. A written hearing request must be received by the AMA **no later than 15 calendar days from the date of the Associate Commissioner's letter.**

107.4 Cost Sharing (Copayment)

Copayment does not apply to services provided by Waiver service providers.

107.5 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

Waiver service providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claims processing turnaround
- Ability to immediately correct claim errors
- Online adjustments capability
- Enhanced access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When an attachment is required, a hard copy CMS-1500 claim form must be submitted. TA Waiver for Adults providers must file claims on a UB-04 claim form when filing hard copy. Medicare-related claims must be filed using the Institutional/Medicare-related claim form for TA Waiver recipients.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

107.5.1 Time Limit for Filing Claims

The operating agencies for the E&D and SAIL waiver have 120 days at the end of the waiver year to process claims. LHW Waiver, TA Waiver for Adults, ID, CWP, and ACT Waiver claims are to be filed within one year of the date of service. Refer to Section 5.1.4, Filing Limits and Approved Exceptions, for more information regarding timely filing limits and exceptions.

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107.5.2 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, AMA Plaza 330 North Wabash Ave, Suite 39300 Chicago, IL 60611-5885, or 1-800-621-8335.

NOTE:

ICD-9 or ICD-10 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

107.5.3 Procedure Codes

The following procedure codes apply when filing claims for E&D Waiver services:

Code	*Description*	*PA Required?*
T1016-UA	Case Management	No
T1019-UA	Personal Care	No
S5102-UA	Adult Day Health	No
T1005-UA	Respite Care – Skilled– Billed per hour	No
S5150-UA	Respite Care – Unskilled	No
S5130-UA	Homemaker	No
S5135-UA	Companion	No
S5170-UA	Waiver Frozen Meals	No
S5170-SC	Waiver Shelf-Stable Meals	No
S5170	Waiver Breakfast Meals	No
S5160-UA	Personal Emergency Response System (PERS) Installation	No
S5161-UA	Personal Emergency Response System (PERS) Monthly	No
T2029-UA	Assistive Technology/Durable Medical Equipment	Yes
T2028-UA	Medical Supplies	No
T1001-UA	Supervisory Visits	No
S9123-UA	Skilled Nursing (RN)	No
S9124-UA	Skilled Nursing (LPN)	No
S5121-UA	Pest Control Services	No
S5165-UA	Home Modifications	Yes

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The following procedure codes apply when filing claims for SAIL Waiver services. These services are limited to recipients age 18 and over.

Code	*Description*	*PA Required?*
T1016-UB	Case Management	No
T1019-UB	Personal Care Services	No
S5165-UB	Environmental Accessibility Adaptations	Yes
T2028-UB	Medical Supplies – (exempt from TPL)	No
T2028-UB & SC	Minor Assistive Technology	No
S5160-UB	Personal Emergency Response Systems/Initial (exempt from TPL)	Yes
S5161-UB	Personal Emergency Response Systems/Monthly Service Fee	No
T2029-UB	Assistive Technology	Yes
S5125-UB	Personal Assistance Services	No
T2025-UB	Evaluation for Assistive Technology	No
T2035-UB	Assistive Technology Repairs	No
S5150-UB	Unskilled Respite Care	No
S5121-UB	Pest Control Service	No

The following procedure codes apply when filing claims for Intellectual Disabilities services:

Code	*Description*	*PA Required?*
T2021-UC & HW	Day Habilitation Services- Level 1	No
T2021-UC & TF	Day Habilitation Services-Level 2	No
T2021-UC & TG	Day Habilitation Services-Level 3	No
T2021-UC & HK	Day Habilitation Services-Level 4	No
T2021-UC & HW & SE	Day Habilitation Services w/ transportation- Level 1	No
T2021-UC & TF & SE	Day Habilitation Services w/transportation-Level 2	No
T2021-UC & TG & SE	Day Habilitation Services w/transportation-Level 3	No
T2021-UC & HK & SE	Day Habilitation Services w/transportation-Level 4	No
T2016-UC	Residential Habilitation Training Services	No
S5150-UC	In-home Respite Care	No
S5150 UC & HW	Self- Directed In- Home Respite Care	No
T1005-UC	Out-of-Home Respite	No
T1005 UC & HW	Self- Directed Out-of-Home Respite Care	No
T2017-UC	In-Home Residential Habilitation Training Services	No
T2019-UC	Supported Employment Services	No

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Code	*Description*	*PA Required?*
T2019-UC & HW	Individual Assessment/Discovery	No
T2019-UC & HN	Individual Job Coach	No
T2019-UC & HO	Individual Job Developer	No
T2015-UC	Prevocational Services	No
97110-UC	Physical Therapy Services	No
97535-UC	Occupational Therapy Services	No
92507-UC	Speech and Language Therapy Services	No
T1019-UC	Personal Care Services	No
T1019-UC & HN	Self-Directed Personal Care	No
T1019-UC & HW	Personal Care on Worksite Services	No
T2001-UC	Personal Care Transportation Services	No
S5135-UC	Companion Services	No
S5135-UC & HW	Self-Directed Companion Services	No
H2019-UC & HP	Positive Behavior Support Services-Level 1	No
H2019-UC & HP & SE	Self-Directed Positive Behavior Support Services – Level 1	No
H2019-UC & HN	Positive Behavior Support Services-Level 2	No
H2019-UC & HN & SE	Self-Directed Positive Behavior Support Services – Level 2	No
H2019-UC & HM	Positive Behavior Support Services-Level 3	No
H2019-UC & HM & SE	Self-Directed Positive Behavior Support Services– Level 3	No
S5165-UC	Environmental Accessibility Adaptations Services	No
S5165-UC & HW	Self-Directed Environmental Accessibility Adaptations Services	No
S9123-UC	Skilled Nursing Services-RN	No
S9123-UC & HW	Self-Directed-RN	No
S9124-UC	Skilled Nursing Services-LPN	No
S9124-UC & HW	Self-Directed-LPN	No
T2028-UC	Specialized Medical Supplies Services	No
T2028-UC & HW	Self-Directed Medical Supplies	No
T2029-UC	Assistive Technology Services	No
T2029-UC & HW	Assistive Technology Services	No
H2015-UC	Community Specialist Services	No
H2015-UC & HW	Self-Directed Community Specialist	No
H2011-UC	Crisis Intervention Services	No
T1999-UC	Individual Directed Goods and Services	No
H2014-UC	Benefits Counseling Services	No

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Code	*Description*	*PA Required?*
H2014 UC & HW	Benefits Reporting Assistance Services	No
H2021-UC	Community Experience Services 1:1	No
H2021-UC & SE	Community Experience Small Group	No
T2025-UC	Housing Stabilization Service	No
S0215-UC	Supported Employment Transportation Services	
S5160-UC	Personal Emergency Response System Services (initial)	No
S5160-UC & HW	Self-Directed Personal Emergency Response System (initial)	No
S5161-UC	Personal Emergency Response System Services (Monthly service fee)	No
S5161-UC & HW	Self-Directed Personal Emergency Response System (Monthly service fee)	No
T1028- UC	Remote Supports Services- Installation of Tech	No
T1028- UC:U7	Remote Supports Services- Assessment, Plan, Protocols- Remote Supports Provider	No
T1028- UC:U8	Remote Supports Services- Assessment, Plan, Protocols- Back-up Supports Provider	No
T2033- UC	Remote Supports Services- On- Call	No
T2033- UC:U7	Remote Supports Services- Monitoring per Hour	No
T2033- UC:U8	Remote Supports Services- Monitoring per Month	No
T1028- UC	Remote Supports Services- Installation of Tech	No

The following procedure codes apply when filing claims for CWP Waiver services:

Code	*Description*	*PA Required?*
92507	Speech and Language Therapy	No
97110	Physical Therapy	No
97535	Occupational Therapy	No
G9005	Support Coordination – Children/Transition-Age Youth Ages 3-21	No
G9005- HE	Support Coordination – Children/Transition- Age Youth Ages 3-21	No
G9005- HI	Support Coordination – Children/Transition- Age Youth Ages 3-21	No
G9005- HO	Support Coordination – Children/Transition- Age Youth Ages 3-21	No
G9005- TF	Support Coordination – Children/Transition- Age Youth Ages 3-21	No
G9005- TG	Support Coordination – Children/Transition- Age Youth Ages 3-21	No
G9008	Support Coordination – Adults Ages 22+	No
G9008- HI	Support Coordination – Adults Ages 22+	No
G9008- HO	Support Coordination – Adults Ages 22+	No
G9008- TF	Support Coordination – Adults Ages 22+	No
G9008- HE	Support Coordination – Adults Ages 22+	No
G9008- TG	Support Coordination – Adults Ages 22+	No
H2014- SE	Work Incentive Benefits Counseling	No
H2014	Financial Literacy Counseling	No

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Code	*Description*	*PA Required?*
H2019- HN	Positive Behavioral Supports: Non-Crisis Consultation Services	No
H2019	Positive Behavioral Supports: Crisis Intervention and Stabilization	No
H2021- HN	Community Integration Connections and Skills Training – CWP -1:1	No
H2021- HO	Community Integration Connections and Skills Training – CWP -1:2	No
H2021- HP	Community Integration Connections and Skills Training – CWP -1:3	No
H2021- HN & HW	Community Integration Connections and Skills Training – CWP -1:2 Self- Directed	No
H2021- HO & HW	Community Integration Connections and Skills Training – CWP -1:1- Self-Directed	No
H2021- HP & HW	Community Integration Connections and Skills Training – CWP -1:3- Self-Directed	No
S5125- HE	Personal Assistance - Home	No
S5125- HE & HW	Personal Assistance – Home – Self-Directed	No
S5125- HE & HO & HW	Personal Assistance – Home Family Self Directed	No
S5125- HW	Personal Assistance – Community Self-Directed	No
S5125	Personal Assistance - Community	No
S5150- HI	Breaks and Opportunities (Respite) - Emergency	No
S5150- HI & HW	Breaks and Opportunities (Respite) – Emergency Self-Directed	No
S5150- HW & SE	Breaks and Opportunities (Planned Respite) – Self-Directed Daily -CWP	No
S5150- HW	Breaks and Opportunities (Planned Respite) – HOURLY- CWP Self-Directed	No
S5150- SE	Breaks and Opportunities (Planned Respite) – DAILY - CWP	No
S5150	Breaks and Opportunities (Planned Respite) – HOURLY CWP	No
S5160- HE	Remote Supports – Assmt., Plan, Protocols – Back-up Spts. Prov.	No
S5160- HI	Remote Supports – Installation of Tech	No
S5160- HO	Remote Supports - Assmt., Plan, Protocols – Remote Spts. Prov.	No
S5161-HE	Remote Supports – On-Call	No
S5161- HI	Remote Supports - Monitoring	No
S5161- HO	Remote Supports - Monitoring	No
S5165	Minor Home Modifications	No
S9123	Skilled Nursing – RN	No
S9123- HW	Skilled Nursing – RN Self-Directed	No
S9124	Skilled Nursing – LPN	No
S9124- HW	Skilled Nursing – LPN Self-Directed	No
T1999	Individual Goods and Services	No
T2001- HE	Community Transportation – Agency Paid Driver with Residential Service	No
T2001- HI	Community Transportation – Agency Vol. Driver with Residential Service	No
T2001- HW & SE	Self-Directed Community Transportation – With CIE	No
T2001- HW	Self-Directed Community Transportation	No

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Code	*Description*	*PA Required?*
T2001-SE	Community Transportation – Agency Paid Driver-No Residential Service	No
T2001	Community Transportation – Agency Volunteer Driver -No Residential Service	No
T2012	Natural Support or Caregiver Education and Training	No
T2012- HW	Natural Support or Caregiver Education and Training – Self-Directed	No
T2013	PEER Specialist	No
T2015	Integrated Employment Path Services 1-1	No
T2015- HO	Integrated Employment Path Services 1-8	No
T2015- HW	Integrated Employment Path Services 1-2	No
T2016	Adult Family Home - CWP	No
T2016- SE	Community-Based Residential Services	No
T2019	Co-worker Supports - Employer	No
T2019- HE & HK	Supported Employment – Small Group 2-3	No
T2019- HE & HW & TF	Supported Employment – Individual Job Coaching months 7-12 <80% Self-Directed	No
T2019- HE & HW & TG	Supported Employment – Individual Job Coaching 25+ months 40%-64% Self-Directed	No
T2019- HE & TF	Supported Employment Individual Job Coaching months 13-24 60% - 74%	No
T2019- HE & TG	Supported Employment Individual Job Coaching 25+months 40%-64%	No
T2019- HI & HK	Supported Employment Small Group:4	No
T2019- HI & HW &TF	Supported Employment Individual Job Coaching months 13-24: <60% Self-Directed	No
T2019- HI & HW &TG	Supported Employment Individual Job Coaching 25+months: <40% Self-Directed	No
T2019- HI & TF	Supported Employment Individual Job Coaching: months 13-24:<60%	No
T2019- HI & TG	Supported Employment Individual Job Coaching: 25+ months: <40%	No
T2019- HK & HW & SE	Supported Employment Individual Job Development – Self-Directed	No
T2019- HK & HW	Supported Employment Individual Job Development Plan – Self-Directed	No
T2019- HK & SE	Supported Employment Individual Job Development Plan	No
T2019- HK	Supported Employment Individual Job Development	No
T2019- HN & HW & TF	Supported Employment Individual Job Coaching: months 13-24: 60%-74% Self-Directed	No
T2019- HN & HW	Supported Employment Individual Discovery self-directed	No
T2019- HN & TF	Supported Employment Individual Job Coaching: months 7-12: 90%-100%	No
T2019- HN	Supported Employment Individual Discovery	No
T2019 HO & HW & TF	Supported Employment Individual Job Coaching: months 7-12: 80% -89% Self-Directed	No
T2019- HO & HW	Supported Employment Individual Career Advancement: Job Self-Directed	No
T2019- HO & TF	Supported Employment Individual Job Coaching: months 7-12: 80-% - 89%	No

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Code	*Description*	*PA Required?*
T2019- HO	Supported Employment Individual Career Advancement: Job	No
T2019- HP & HW & TF	Supported Employment Individual Job Coaching: months 7-12: 90% - 100% Self-Directed	No
T2019- HP & HW	Supported Employment Individual Career Advancement: Plan Self-Directed	No
T2019- HP & TF	Supported Employment Individual Job Coaching: months 7-12: <80%	No
T2019- HP	Supported Employment Individual Career Advancement: Plan	No
T2019- HW & SE & TF	Supported Employment Individual Exploration Self-Directed	No
T2019- HW & SE &TG	Supported Employment Individual Job Coaching: months 13-24: 75% - 100% Self-Directed	No
H2023	Supported Employment Individual Job Coaching Stabilization and monitoring	No
H2023- HW	Supported Employment Individual Job Coaching Stabilization and monitoring Self-Directed	No
T2019- HW & TF	Supported Employment Individual Job Coaching: months 1-6 Self-Directed	No
T2019- HW & TG	Supported Employment Individual Job Coaching: months 25+ months 65% - 100% Self-Directed	No
T2019- SE & TF	Supported Employment Individual Exploration	No
T2019- SE & TG	Supported Employment Individual Job Coaching months 13-24: 75% - 100%	No
T2019- TF	Supported Employment Individual Job Coaching months 1-6	No
T2019- TG	Supported Employment Individual Job Coaching: 25+ months: 65% - 100%	No
T2019- SE	Co-worker Supports –SE Agency Coordination and oversite	No
T2021- HW	Independent Living Skills Training Self-Directed	No
T2021	Independent Living Skills Training	No
T2025- HE	Housing Start-Up Assistance – Costs Other than Directed Service by Waiver Provider	No
T2025- HO	Family Empowerment and Systems Navigation Counseling	No
T2025	Housing Counseling	No
T2029- SE	Assistive Technology and Adaptive Aids Devices - CWP	No
T2029	Assistive Technology and Adaptive Aids Assessment and/or training – CWP	No
T2032- SE	Supported Living Services: Intensive	No
T2032	Supported Living Services Non-Intensive	No
T2038	Housing Start-up Assistance – Directed Service by Waiver Provider	No

The following procedure codes apply when filing claims for Living at Home Waiver services:

Code	**Description (All services exempt from TPL and MC)**	**PA Required?**
T2017-UD	In-Home Residential Habilitation Training Services	No
T2021-UD & HW	Day Habilitation Services (Level 1)	No

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Code	Description (All services exempt from TPL and MC)	PA Required?
T2021-UD & TF	Day Habilitation Services (Level 2)	No
T2021-UD & TG	Day Habilitation Services (Level 3)	No
T2021-UD & HK	Day Habilitation Services (Level 4)	No
T2021-UD & HW & SE	Day Habilitations Services w/transportation – Level 1	No
T2021-UD & TF & SE	Day Habilitations Services w/transportation – Level 2	No
T2021-UD & TG & SE	Day Habilitations Services w/transportation - Level 3	No
T2021-UD & HK & SE	Day Habilitations Services w/transportation – Level 4	No
T2019-UD	Supported Employment Services	No
T2019-UD & HW	Individual Assessment/Discovery	No
T2019-UD & HN	Individual Job Coach	No
T2019-UD & HO	Individual Job Developer	No
S0215-UD	Supported Employment Transportation-Mile	No
T2015-UD	Prevocational Services	No
S5150-UD	In-Home Respite Care	No
S5150- UD & HW	Self-Directed In-Home Respite Care	No
T1005-UD	Out-of-Home Respite Care	No
T1005- UD & HW	Self-Directed Out-of-Home Respite Care	No
T1019-UD	Personal Care Services	No
T1019-UD & HN	Self-Directed Personal Care	No
T1019-UD & HW	Personal Care on Worksite Services	No
T2001-UD	Personal Care Transportation Services	No
S5135- UD	Companion Services	No
S5135- UD & HW	Self- Directed Companion Services	No
97110-UD	Physical Therapy Services	No
97535-UD	Occupational Therapy Services	No
92507-UD	Speech and Language Therapy Services	No
H2019-UD & HP	Positive Behavior Support Services -Level 1	No
H2019-UD & HP & SE	Self-Directed Positive Behavior Support Services - Level 1	No
H2019-UD & HN	Positive Behavior Support Services -Level 2	No
H2019–UD & HN & SE	Self-Directed Positive Behavior Support Services- Level 2	No
H2019-UD	Positive Behavior Support Services -Level 3	No

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Code	Description (All services exempt from TPL and MC)	PA Required?
& HM		
H2019-UD & HM & SE	Self-Directed Positive Behavior Support Services- Level 3	No
S9123-UD	Skilled Nursing Services RN	No
S9123-UD & HW	Self-Directed Skilled Nursing –RN	No
S9124-UD	Skilled Nursing Services- LPN	No
S9124-UD & HW	Self-Directed Skilled Nursing – LPN	No
S5165-UD	Environmental Accessibility Adaptations Services	No
S5165-UD & HW	Self-Directed Environmental Accessibility Adaptations	No
T2028-UD	Specialized Medical Supplies Services	No
T2028-UD & HW	Self-Directed Medical Supplies	No
T2029-UD	Assistive Technology Services	No
T2029-UD & HW	Assistive Technology Services	No
H2015-UD	Community Specialist Services	No
H2015-UD & HW	Self-Directed Community Specialist	No
H2011-UD	Crisis Intervention Services	No
T1999-UD	Individual Directed Goods and Services	No
H2014-UD	Benefits Counseling Services	No
H2014-UD	Benefits Reporting Assistant Services	No
T2025-UD	Assistance in Community Integration Services	No
H2021 UD	Community Experience Services 1:1	No
H2021-UD & SE	Community Experience Small Group	No
T2025- UD	Housing Stabilization Services	No
S5160 –UD	Personal Emergency Response System Services (initial)	No
S5160-UD & HW	Self-Directed Personal Emergency Response System (initial)	No
S5161-UD	Personal Emergency Response System Services (monthly service fee)	No
S5161-UD & HW	Self-Directed Personal Emergency Response (monthly service fee)	No
T1028- UD	Remote Supports Services- Installation of Tech.	No
T1028-UD:U7	Remote Supports Services- Assessment, Plan, Protocols- Remote Supports Provider	No
T1028-UD:U8	Remote Supports Services- Assessment, Plan, Protocols- Back-up Supports Provider	No
T2033- UD	Remote Supports Services- On- Call	No

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Code	Description (All services exempt from TPL and MC)	PA Required?
T2033-UD:U7	Remote Supports Services- Monitoring per Hour	No
T2033-UD:U8	Remote Supports Services- Monitoring per Month	No

The following procedure codes apply when filing claims for TA Waiver for Adults services:

Code	*Description*	*PA Required?*
S9123-U5	Private Duty Nursing - RN	No
S9124-U5	Private Duty Nursing - LPN	No
T1019-U5	Personal Care/Attendant Service	No
T2028-U5	Medical Supplies and Appliances	No
T2029-U5	Assistive Technology	Yes
S5121-U5	Pest Control Service	No

The following procedure codes apply when filing claims for ACT Waiver services:

Code	*Description*	*PA Required?*
T1016-TF UB	Case Management	No
T1019-TF UB	Personal Care Services	No
S5165-TF UB	Home Modifications	Yes
T2028-TF UB	Medical Supplies – (exempt from TPL)	No
S9123-TF UB	Skilled Nursing (RN)	No
S9124-TF UB	Skilled Nursing (LPN)	No
S5160-TF UB	Personal Emergency Response Systems/Initial (exempt from TPL)	Yes
S5161-TF UB	Personal Emergency Response Systems/Monthly Service Fee	No
T2029-TF UB	Assistive Technology	Yes
S5125-TF UB	Personal Assistance Services	No
T2038-TF UB	Transitional Assistance Service	No
S5130-TF UB	Homemaker Service	No
S5102-TF UB	Adult Day Health	No
T1005-TF UB	Respite Services (Skilled)	No
S5150-TF UB	Respite Services (Unskilled)	No
S5170-TF UB	Home Delivered Meals	No

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Code	Description	PA Required?
S5170-TF SC	Home Delivered Meals (Shelf Stable)	No
S5170-TF UA	Home Delivered Meals (Breakfast)	No
S5135-TF UB	Adult Companion Service	No
S5121-TF UB	Pest Control Service	No

107.5.4 Place of Service Codes

The following place of service codes apply when filing claims for Waiver service:

POS Code	Description
12	Home (Residential) —ID Waiver, SAIL Waiver, LHW, CWP, TA Waiver for Adults and the ACT Waiver.
21	Inpatient Hospital-SAIL Waiver, ACT Waiver
31	Skilled Nursing Facility or Nursing Home-SAIL Waiver, and ACT Waiver
32	Nursing Facility-SAIL Waiver and ACT Waiver
51	Inpatient Psychiatric Facility-SAIL Waiver, and ACT Waiver
54	Intermediate Care Facility/Individuals with Intellectual Disabilities - SAIL Waiver, and ACT Waiver
99	Other Unlisted Facility —ID Waiver, CWP, Elderly & Disabled Waiver, LHW, TA Waiver for Adults, SAIL, and ACT 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 5.8, Required Attachments, for more information on attachments.

107.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
CMS-1500 Claim Filing Instructions	Chapter 5
Alabama Coordinated Health Network (ACHN)	Chapter 40
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N
UB92 Claim Filing Instructions	Chapter 5

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108

108 Early Intervention Services

Early Intervention (EI) Services are specialty-oriented services delivered to infants/toddlers enrolled in Alabama's Early Intervention System (AEIS). Alabama's eligibility definition for Early Intervention is: a child birth to three years of age with a diagnosed mental or physical condition which has a high probability of resulting in developmental delay or who is experiencing a 25% delay in one or more of the five developmental areas: cognitive, physical to include vision/hearing, communication, social/emotional and adaptive. EI services include the following services provided in the natural environment unless otherwise denoted on the Individualized Family Service Plan (IFSP):

Early Intervention Services include:

- Intake Evaluation
- Basic Living Skills
- Audiology
- Family Support
- Physician Evaluation and Management Services
- Occupational Therapy (OT)
- Physical Therapy (PT)
- Psychological Testing
- Speech and Language Pathology
- Vision Services
- Treatment Plan Review

Eligible infants/toddlers receive EI Services through providers who contract with Medicaid to provide services to the eligible population.

108.1 Enrollment

The Alabama Medicaid Agency fiscal agent enrolls EI providers who meet the licensure and/or certification requirements of the State of Alabama, the Code of Federal Regulations, the *Standards For Serving Young Children With Disabilities and Their Families In Alabama* (EI personnel standards), the *Alabama Medicaid Administrative Code,* and the *Alabama Medicaid Provider Manual.*

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

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National Provider Identifier, Type, and Specialty

A provider who contracts with Alabama Medicaid as an EI provider is added to the Medicaid system with the National Provider Identifiers provided at the time application is made. Appropriate provider specialty codes are assigned to enable the provider to submit requests and receive reimbursement for EI-related claims.

NOTE:

The 10-digit NPI is required when filing a claim.

- EI providers are assigned a provider type of 63 (Services).

Valid providers for Early Intervention through contractual agreements include the following:

- Alabama Institute for Deaf and Blind (AIDB)
- Children's Rehabilitation Services (ADRS/CRS)
- Department of Mental Health (DMH)
- Division of Early Intervention (ADRS/EI)

NOTE:

CRS Specialty Clinics are not part of Early Intervention.

Enrollment Policy

Providers are qualified personnel who provide services within the natural environment unless otherwise denoted on the IFSP and provide services through a team approach.

Providers must meet recognized standards for infants/toddlers under AEIS and include the following disciplines, at a minimum:

- Audiologists
- Family Therapists
- Nurses
- Registered Dietitians
- Occupational Therapists
- Orientation & Mobility Specialists
- Physical Therapists
- Psychologists
- Social Worker
- Service Coordinators
- Special Instructors
- Speech & Language Pathologists
- Vision Specialists

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108.2 Benefits and Limitations

All providers must participate in the development of the IFSP. All services must be provided as outlined on the IFSP.

Case management/service coordination is an integral part of Alabama's EI System. Case managers/service coordinators provide services such as evaluation/assessment, IFSP development, and coordination of services. Please see Chapter 106 addressing Targeted Case Management for Handicapped Children.

IFSP Team

The IFSP teams are usually comprised of family support personnel, parents/family members, and other EI personnel as they relate to the identified needs of the infant/toddler. The team will establish a written IFSP. The IFSP team then implements this plan.

108.2.1 Covered Services

EI Services do not include services rendered under other Medicaid programs.

EI Services are covered when provided by a Medicaid-enrolled early intervention provider and are subject to retrospective review, which may result in monies being recouped. Payments are subject to recoupment when the documentation is insufficient to support the services billed (i.e. must be documented "with justification").

Types of covered services provided include, but are not limited to:

- Intake Evaluation
- Basic Living Skills
- Therapy (physical, speech/language, occupational)
- Family Support
- Audiology services
- Physician Evaluation and Management services
- Psychological testing
- Vision services
- Treatment Plan Review

An IFSP is required for each infant/toddler and Family Support Personnel is responsible for arranging specialty and needed services for the family.

The following is a description of each EI service. Please see the EI Services Grid for Billing Unit, Daily Maximum, Maximum Units and Billing Restrictions.

Intake Evaluation (90801 with TL modifier for dates of service prior to 01/01/2013) (T1023 with TL modifier for dates of service 01/01/2013 and thereafter)

Definition

Initial evaluation to determine child's eligibility for EI. Child will undergo an evaluation of all five developmental areas with a second procedure to confirm delay in at least one of the developmental areas. The evaluator(s) will determine child's functioning level and provide written report which will indicate child's functioning level in terms of percentage of delay or no delay. Eligibility determination will be

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made by a multidisciplinary team. Ongoing assessment will be conducted to determine the child's continued eligibility for EI.

Key service functions include the following:

- A voluntary family assessment conducted in a personal interview
- Evaluation of the child's functioning level in the five developmental areas: cognitive, physical (includes vision & hearing), communication, social/emotional and adaptive
- Review of pertinent medical records or other developmental information
- Screening of vision and hearing
- Written report

Qualified staff

Evaluations & assessments may be performed by individuals who meet the test protocol for administering such tests as the Battelle, Bayley, E-LAP, DAYC, IDA, etc. These individuals include:

- Targeted case manager
- Family Support personnel (completion of the AEIS SI webinar is not required)
- Certified social worker licensed under Alabama law
- Occupational, Physical or Speech therapist licensed under Alabama law
- Audiologist licensed under Alabama law
- Individuals meeting ICC personnel standards for Family Training/Counseling/Home visits
- Registered nurse licensed under Alabama law
- Registered dietitian licensed under Alabama law
- Psychologist licensed under Alabama law
- School psychologist or psychometrist meeting Alabama's ICC personnel standards
- Individuals who have a bachelor's degree in ECSE/VI/HI who meet Alabama's ICC personnel standards (e.g. special instructors, family trainers, home visitors, service coordinators, social workers, etc.)
- Orientation & Mobility specialists as certified by the Association for Education & Rehabilitation of the Blind and Visually Impaired

Location

Service may be delivered in the child's natural environment or service provider location.

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Basic Living Skills (H0036 with TL modifier)

Definition

Functional evaluation of the child in the child's natural environment. The purchasing, leasing or otherwise providing for the acquisition of assistive technology devices. Selecting, designing, adapting, or maintaining an AT device, in order to assist with basic living skills. Any training and/or technical assistance in developing or maintaining basic living skills to improve functional capacity.

Key service functions include the following:

- Evaluating the child's functioning level and determining need of assistive device
- Acquiring the device and providing maintenance or adaptation to the device.
- Providing child, family and providers on the appropriate use of the device so that the child receives the maximum benefit.
- Progress reports and physical participation in IFSP meetings
- Service will be provided per the IFSP

Qualified staff

- Occupational, Physical or Speech therapist licensed under Alabama law
- Certified social worker licensed under Alabama law
- Rehabilitation technology specialist
- Other individuals as defined by the ICC Personnel standards

Location

Service may be delivered in the child's natural environment or service provider location, with justification.

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Audiology (92507, 92508, 92550, 92552, 92553, 92555, 92556, 92557, 92567, 92568, 92579, 92582, 92583, 92585, 92586, and 92587— all codes must be submitted with TL modifier)

Definition

Identification of children with auditory impairment. A determination of range, nature and degree of hearing loss and communication functions of the child. The provision of auditory training, aural rehabilitation, speech reading and listening device orientation and training. The determination of the child's need for individual amplification, including selecting, fitting and dispensing appropriate listening and vibrotactile devices and evaluating the effectiveness of those devices.

Key service functions include the following:

- Identifying auditory impairment based on appropriate audiologic screening techniques
- Determining the range and degree of hearing loss and communication functions
- Providing auditory training, aural rehabilitation, speech reading and listening device orientation
- Selecting, fitting and dispensing appropriate listening and vibrotactile devices and evaluating the effectiveness of those devices
- Progress reports and physical participation in IFSP meetings
- Service will be provided per the IFSP

Qualified staff

- Audiologist licensed under Alabama law
- Speech therapist licensed under Alabama law
- Hearing Aid Dealers
- Licensed Doctor of Medicine
- Staff will meet the ICC approved Personnel Standards for AEIS

Location

Service may be delivered in the child's natural environment or service provider location, with justification.

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Family Support (H2027 with TL modifier)

Definition

Services provided to assist the family of an eligible child in understanding the special needs of the child and enhancing the child's development.

There are 2 distinct areas of service included in Family Support: Service Coordination and Special Instruction.

Service Coordination

(Billable activities under H2027 will begin once a child is determined to be eligible for services)

- Providing families with a single point of contact for Early Intervention (EI) services
- Development of Individualized Family Service Plan (IFSP)
- Discussion of evaluation results that determine the child is eligible for early intervention services
- Completing all EI procedural safeguard requirements to allow a child (referral) to receive early intervention services
- Review of eight core values and the early intervention vital message
    - Family centered
    - Developmentally appropriate
    - Individualized
    - Natural environment
    - Train/Equip
    - Collaborative
    - Routines based
    - Evidence-Based
- Completion of voluntary family assessment
- Development of IFSP document
- Assisting families in gaining access to the EI services and other services identified in the IFSP
- Ensuring all monthly services are scheduled according to planned services per IFSP
- Review of progress notes and family support notes to ensure that all services are being provided per the IFSP including frequency/duration and location and that current outcomes are being addressed
- Preparing a social/emotional developmental assessment of the child within the family context
- Making home visits to evaluate a child's living conditions and patterns of parent-child interaction

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- Working with the family's living situation (home, community and other locations where early intervention services are provided) that affect the child's maximum utilization of early intervention services
- Attending home visits with service providers to ensure that services are being provided per the IFSP (outcomes are addressed, caregiver training, follow-through)
- Identifying and coordinating community resources and services to enable the child and family to receive maximum benefit from EI services
- Facilitating and participating in the review of the IFSP at 6 month and annual intervals
- Update of IFSP planned services at request of parent or guardian
- Communicate information between service providers and caregiver through ongoing contact among various team members via phone, email, or face-to-face contact
- Facilitating the timely delivery of services
- Assisting family in the transition process by facilitating 27 month and 33 month transition meeting. Ensure LEA receives referral in timely manner
- The LEA Referral Meeting CANNOT be billed under the EI Medicaid Option
- Closing a child's case with early intervention through contact with parent, ensuring that they understand EI services are ending and helping to connect the family to other resources when appropriate.
- Service Coordination provided to a child who is in the hospital, etc. CANNOT be billed under the EI Medicaid Option.

Qualified Staff for Service Coordinator

Individuals must meet the ICC approved personnel standards and attend mandatory CPSD trainings.

Special Instruction

- Working with the child and family to enhance the child's development and assure family follow through with routine activities on a daily basis
- Visiting the child in their home environment and addressing specific outcomes with the family/caregivers
- Promoting the child's acquisition of skills in a variety of developmental areas, including cognitive processes and social interaction
- Providing a family support note after each visit
- Providing developmental and functionally appropriate services
- Service will be provided per IFSP:

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- Training the family regarding specific information regarding the child's disability
- How to carry out activities as indicated in the IFSP
- Home visits are a support to accomplished activities under the IFSP
- Social/emotional development assessment
- Enhancing the developmental skills of the child
- Providing structured intervention and routine, functional approach to children diagnosed with autism spectrum disorder.

Qualified Staff for Special Instruction

Individuals must meet ICC approved personnel standards and attend mandatory CSPD training.

Location

Service may be provided in the child's home environment or the service provider's location, with justification.

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Physician Evaluation and Management Services (99382 with TL modifier)

Definition

Services provided by a physician to determine a child's developmental status and need for early intervention services.

Key services functions include the following:

- To evaluate the child's on-going eligibility for AEIS.
- To determine if the child has a physical or mental condition that would make the child eligible, if no such diagnosis previously existed and the child was no longer experiencing a 25% delay to maintain eligibility for AEIS.
- Progress reports and physical participation in IFSP meetings
- Service will be provided per the IFSP

Qualified staff

- Licensed doctor of medicine

Location

Service may be provided in the child's natural environment or service provider location, with justification.

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Occupational Therapy (97165, 97166, 97167, 97168, 97110, 97530, 97532, and 97533 — all codes must be submitted with the TL modifier)

Definition

Services to address the functional needs of the child related to adaptive development, adaptive behavior and play and sensory, motor and postural development. These services are designed to improve the child's functional ability to perform tasks in the home and community settings.

Key service functions include the following:

- Identification, assessment and intervention
- Adaptation of the environment, and selection, design and fabrication of assistive and orthotic devices to facilitate development and promote the acquisition of functional skills
- Prevention or minimization of the impact of initial or future impairment, delay in development or loss of functional ability
- Providing developmental and functionally appropriate services
- Teaming as appropriate with other IFSP team members in achieving the outcomes in the child's IFSP
- Progress reports and physical participation in IFSP meetings
- Service will be provided per the IFSP

Qualified staff

- Occupational therapist licensed under Alabama law
- Staff will meet the ICC approved Personnel Standards for AEIS

Location

Service may be provided in the child's natural environment or service provider location, with justification.

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Physical Therapy (97161, 97162, 97163, 97164, 97110, 97112, 97530, 97532, 97533, and 97760 — all codes must be submitted with the TL modifier)

Definition

Services to address the promotion of sensorimotor function through enhancement of musculoskeletal status, neurobehavioral organization, perceptual and motor development, cardiopulmonary status and effective environmental adaptation.

Key service functions include the following:

- Screening, evaluation and assessment of infants and toddlers to identify movement dysfunction
- Obtaining, interpreting and integrating information appropriate to program planning to prevent, alleviate or compensate for movement dysfunction and related functional problems
- Providing individual and group services or treatment to prevent, alleviate or compensate for movement dysfunction and related functional problems
- Providing developmental and functionally appropriate services
- Teaming as appropriate with other IFSP team members in achieving the outcomes in the child's IFSP
- Progress reports and physical participation in IFSP meetings
- Service will be provided per the IFSP

Qualified staff

- Physical therapist licensed under Alabama law
- Staff will meet the ICC approved Personnel Standards for AEIS

Location

Service may be provided in the child's natural environment or service provider location, with justification.

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Psychological testing (96111 with TL modifier) Definition

Administering psychological and developmental tests and other assessment procedures. Interpreting assessment results. Obtaining, integrating and interpreting information about the child behavior and child and family conditions related to learning, mental health and development. Planning and managing a program of psychological services, including psychological counseling for children and parents, family counseling, consultation on child development, parent training and education programs.

Key service functions include the following:

- Administering developmental tests
- Interpreting assessment results
- Planning psychological services and counseling to family related to the child's development
- Progress reports and physical participation in IFSP meetings
- Service will be provided per the IFSP

Qualified staff

- Psychologist licensed under Alabama law
- School psychologist certified by the Alabama State Department of Education for AA Certificate and/or holds the National Certification in School Psychology
- School Psychometrics certified by the Alabama State Department of Education for the A Certificate and/or listed in the Alabama Roster of Approved Psychologists and Psychometrics for Testing Children Referred for Placement in Special Education Classes
- Staff will meet the ICC approved Personnel Standards for AEIS

Location

Service may be provided in the child's natural environment or service provider location, with justification.

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Speech-Language Pathology (92523, 92507, and 92508 — all codes must be submitted with the TL modifier)

Definition

Identification of children with communicative or oropharyngeal disorders and delays in the development of communication skills, including the diagnosis and appraisal of specific disorders and delays in those skills. Referral for medical or other professional services necessary for the habilitation or rehabilitation of children with communicative or oropharyngeal disorders and delays in the development of communication skills. Provision of services for the habilitation, rehabilitation or prevention of communicative or oropharyngeal disorders and delays in the development of communication skills.

Key service functions include the following:

- Identifying and evaluating delays in the development of communication skills
- Providing services to address the developmental delays of the child's communication skills
- Speech services include a variety of techniques, to include, but not limited to: speech, cued speech, auditory-verbal therapy, etc.
- Providing developmental and functionally appropriate services
- Teaming as appropriate with other IFSP team members in achieving the outcomes in the child's IFSP
- Progress reports and physical participation in IFSP meetings
- Service will be provided per the IFSP

Qualified staff

- Staff will meet the ICC approved Personnel Standards for AEIS

Location

Service may be provided in the child's natural environment or service provider location, with justification.

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Vision services (99173 with TL modifier)

Definition

Evaluation & assessment of visual functioning, including the diagnosis and appraisal of specific visual disorder, delays and abilities. Referral for medical or other professional services necessary for the habilitation and rehabilitation of visual functioning disorders or both. Communication skills training, orientation and mobility training for all environments, visual training, independent living skills training, and additional training necessary to activate visual motor abilities.

Key service functions include the following:

- Determining the visual functioning level of the child
- Orientation and mobility training for all environments
- Visual training
- Independent living skills training
- Providing developmental and functionally appropriate services
- Teaming as appropriate with other IFSP team members in achieving the outcomes in the child's IFSP
- Progress reports and physical participation in IFSP meetings
- Service will be provided per the IFSP

Qualified staff

- Individuals with a bachelor's degree in the Education of the Visually Impaired and have an Alabama Class B teacher certificate
- Orientation & Mobility specialists as certified by the Association for Education & Rehabilitation of the Blind and Visually Impaired
- Licensed doctor of Optometry or Ophthalmologist
- Occupational or Physical therapist licensed under Alabama law
- Staff will meet the ICC approved Personnel Standards for AEIS

Location

Service may be provided in the child's natural environment or service provider location, with justification.

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Treatment Plan Review (H0032 with TL modifier)

Definition

Review and/or revision of a client's IFSP by qualified staff members. Treatment outcomes will be written in family friendly terms, based on the family's priorities and concerns. A variety of disciplines may be involved based on the results of the multidisciplinary evaluation and assessment that determined the child's eligibility for EI. The meeting for this review will only occur if the family is present.

- The IFSP is reviewed with the family
- Treatment outcomes are functional in nature
- Modification or revision of treatment outcomes or services are made as necessary and coordinated through the Family Support Personnel
- After the initial IFSP is written, the plan will be reviewed, at a minimum, every six months
- The 6 month review can be done via telephone with the parent by the therapist or special instructor. A sign-in sheet is required as documentation for billing the 6 month review
- IFSP reviews may also be conducted via various videoconference mediums

Qualified staff

See staff listed under previous EI services

Location

Service may be provided in the child's natural environment or via telephone or various videoconference mediums.

108.2.2 Reimbursement

Claims may be submitted for reimbursement for multiple early intervention (EI) services to a recipient on a given day. However, a provider may only submit one claim per day for a particular service to a recipient. For example, an infant may receive service coordination, special instruction, and speech therapy all on date of service. Each face to face contact for speech therapy and special instruction with the infant would constitute an encounter. Each contact for service coordination with the family, whether face-to-face or other would also constitute an encounter.

Each discipline will be able to submit a claim for reimbursement: H2027-family support (service coordination) in the office or other, if justified, and speech therapy in the home or other, if justified. Providers will be able to submit a claim for each individual service to the child per IFSP. If a provider is qualified to provide more than one EI service, then each claim for reimbursement and documentation should clearly distinguish which service was rendered and there should be a clear delineation of types of services provided to the infant/toddler.

*Covered services are face-to-face contacts during which a professional team member provides an EI service to an infant/toddler. They are identified based on the data from the individual EI records.

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* An exception to face-to-face contacts is the 6 month review of the treatment plan. The 6 month review plan is allowable to be billed when the service plan is reviewed by telephone. It may still be done face-to-face if preferred by the parent.

Face-to-face contact is also defined as utilizing various videoconference mediums.

The definition of a professional team member depends upon the type of service being delivered.

108.2.3 Maintenance of Records

The provider must make available to the Alabama Medicaid Agency at no charge all information regarding claims for services provided to eligible recipients. The provider will permit access to all records and facilities for the purpose of claims audit, program monitoring, and utilization review by duly authorized representatives of federal and state agencies. The provider maintains complete and accurate fiscal records that fully disclose the extent and cost of services.

The provider maintains documentation of progress notes and dates of service.

The provider maintains all records for a period of at least three years plus the current fiscal year. If audit, litigation, or other legal action by or on behalf of the state or federal government has begun but is not completed at the end of the three-year period, the provider retains the records until the legal action is resolved. The provider must keep records in a format that facilitates the establishment of a complete audit trail in the event the items are audited.

108.3 Prior Authorization and Referral Requirements

Early Intervention codes do not require prior authorization. Refer to Chapter 4, Obtaining Prior Authorization, for general guidelines.

When filing claims for recipients enrolled in the Alabama Coordinated Health Network (ACHN) Program, refer to Chapter 40 to determine whether your services require a referral from the Primary Care Physician (PCP).

108.4 Cost Sharing (Copayment)

Copayment does not apply to services provided by EI Providers.

108.5 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

EI Providers that bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Online adjustment functions
- Enhanced access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

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This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

108.5.1 Time Limit for Filing Claims

Medicaid requires all claims for EI services to be filed within one year from the date of service. Refer to Section 5.1.5, Filing Limits and Approved Exceptions, for more information regarding timely filing limits and exceptions.

108.5.2 Procedure Codes and Modifiers

Medicaid uses the Healthcare Common Procedure Coding System (HCPCS). HCPCS is composed of the following:

- American Medical Association's Current Procedural Terminology (CPT)
- Nationally assigned codes developed for Medicare

The CPT manual lists most procedure codes required by Medicaid. This manual may be obtained by contacting the Order Department, American Medical Association, 515 North State Street, Chicago, IL 60610-9986. The (837) Professional, Institutional and Dental electronic claims and the paper claim have been modified to accept up to four Procedure Code Modifiers.

The following procedure codes have been approved for billing by Early Intervention providers.

EI Services Grid

(All these Procedure Codes **require** a TL modifier)

Procedure Code	*Billing Unit*	*Daily Maximum*	*Maximum Units-Annual*	*Description*	*Same Day Services Not Allowed (Billing Restrictions)*
T1023	Episode	3	6	Intake Evaluation	All other EI services except TCM and Family Support Personnel NOTE: Two different disciplines may bill for this service on the same day.
H0036	1	2	24	Basic Living Skills	May not be billed by two different disciplines on the same day with the same provider specialty

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Procedure Code	*Billing Unit*	*Daily Maximum*	*Maximum Units-Annual*	*Description*	*Same Day Services Not Allowed (Billing Restrictions)*
92507 92508 92550 92552 92553 92555 92556 92557 92567 92568 92579 92582 92583 92585 92586 92587	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	104 104 48 48 48 48 48 48 48 48 48 48 48 48 48 48	Audiology services	May not be billed by two different disciplines on the same day with the same provider specialty
H2027	15 min	24	600	Family Support	May not be billed by two different disciplines on the same day with the same provider specialty. SW may not be provided in conjunction with services from AL Dept of Human Resources
99382	30 min	4	10	Physician Evaluation and Management Services	May not be billed by two different disciplines on the same day with the same provider specialty
97165 97166 97167 97168 97110 97530 97532 97533	30 min 45 min 60 min 30 min 15 min 15 min 15 min 15 min	1 1 1 1 4 4 4 4	1 1 1 192 192 192 192	Occupational Therapy	May not be billed by two different disciplines on the same day.
97161 97162 97163 97164 97110 97112 97530 97532 97533 97760	20 min 30 min 45 min 20 min 15 min 15 min 15 min 15 min 15 min 15 min	1 1 1 1 4 4 4 4 4 4	 1 1 1 1 192 192 192 192 192 192	Physical Therapy	May not be billed by two different disciplines on the same day.
96111	1	1	3	Psychological testing	May not be billed by two different disciplines on the same day with the same provider specialty

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Procedure Code	*Billing Unit*	*Daily Maximum*	*Maximum Units-Annual*	*Description*	*Same Day Services Not Allowed (Billing Restrictions)*
92507 92508 92523	1 1 1	1 1 1	104 104 6	Speech-Language Pathology	May not be billed by two different disciplines on the same day with the same provider specialty
99173	1	1	52	Vision services	May not be billed by two different disciplines on the same day with the same provider specialty
H0032	30 min	10	40	Treatment Plan Review	Individuals must be part of the IFSP team and only one person per discipline can bill for this service on any given day

108.5.3 Place of Service

Claims should be filed with Place of Service (POS) Code 11 (office), 12 (home) *or 99 (daycare)*.

108.5.4 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to the following circumstances:

- Claims With Third Party Denials

Refer to Section 5.8, Required Attachments, for more information on attachments.

108.6 Covered Services Eligible for Telemedicine

Refer to Chapter 112, Telemedicine Services, for general information and limitations.

108.7 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
CMS-1500 Claim Filing Instructions	Chapter 5
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N

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109 PACE

The Program of All-Inclusive Care for the Elderly (PACE) is a unique model of long term care service delivery for the frail elderly living in the community. It is a state plan program of comprehensive care that allows the frail elderly to live in their communities. The program brings together all the medical and social services needed for someone who otherwise might be in a nursing home. A team, including a physician, registered nurse, social worker, therapists and other health professionals, assesses the participant's needs, develops a comprehensive plan of care and provides for total care. Generally, services are provided in an adult day health center, but they may also be given in a participant's home, a hospital, a long-term care facility or a nursing home. Most PACE participants are dually eligible for Medicare and Medicaid benefits. Enrollment in PACE is voluntary and not limited to an individual who is either a Medicare or Medicaid recipient. All participants must be certified as meeting nursing facility level of care according to the criteria established by the state Medicaid Agency prior to enrollment. Once enrolled, PACE becomes the sole source of all Medicare and Medicaid-covered services, as well as any other items, or medical, social or rehabilitation services the PACE interdisciplinary team (IDT) determines a participant needs.

The PACE program receives a fixed monthly capitated payment from Medicare and Medicaid for each participant, depending on their Medicare and Medicaid eligibility. The payments remain the same during the contract year, regardless of the services a participant may need. The PACE provider assumes full financial risk for each participant enrolled in the program.

The purpose of providing PACE care to individuals at risk of institutional care is to protect the health, safety, and dignity of those individuals while reducing Medicaid expenditures for institutional care.

The policy provisions for PACE providers can be found in the *Alabama Medicaid Agency Administrative Code,* Chapter 53 and Part 460 of the Code of Federal Regulations.

109.1 Enrollment

109.1.1 CMS Enrollment and Agreement

An entity that wishes to become a PACE Organization (PO) must complete an application that describes how the entity meets all the requirements to be a PO. The application must first be submitted to Alabama Medicaid Agency (AMA) for review and approval, and then to CMS. AMA will provide the entity with an assurance that is to be submitted with the application sent to CMS by the entity, stating that the entity is qualified to be a PO and that AMA is willing to enter into an agreement with the entity. CMS will then evaluate the application based on the information contained in the application, as well as information obtained by onsite visits conducted by AMA and/or CMS. CMS will notify the entity within 90 days from receipt of the application that the application is approved or denied, or that additional information is required. If additional information is requested, CMS will have an additional 90 days from receipt of the requested information to make a final decision. Once an application is approved, an agreement must be signed by the

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organization, the AMA, and an authorized official of CMS. The agreement is effective for one contract year but may be extended each year unless any party chooses to terminate the agreement. At a minimum, the agreement must include the information required in 42 CFR 460.32.

109.1.2 AMA Enrollment

Once the three-way agreement has been signed by all parties, the entity is to submit a provider application to Gainwell for enrollment as a Medicaid provider. Gainwell will contact the appropriate staff of the Medicaid PACE Unit to verify that the entity has been approved to be a PACE provider.
Gainwell enrolls PACE providers and issues provider contracts to applicants who meet the licensure and/or certification requirements of the State of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code* and the *Alabama Medicaid Provider Manual.*

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.
Federal requirements mandate providers re-validate periodically with the Alabama Medicaid program. Providers will be notified when they are scheduled to re-validate. Failure to re-validate and provide appropriate documentation to complete enrollment will result in an end-date being placed on the provider file. Once a provider file has been closed for failure to timely re-validate, providers will have to submit a new application for enrollment.

National Provider Identifier, Type, and Specialty

A provider who contracts with Alabama Medicaid as a PACE provider is added to the Medicaid system with the National Provider Identifiers provided at the time application is made. Appropriate provider specialty codes are assigned to enable the provider to submit requests and receive reimbursements for PACE related services.

NOTE:
The 10-digit NPI is required when filing a claim.

PACE providers are assigned a provider type of 64 (PACE Organization). The valid specialty for PACE providers is PACE Organization (645).

109.2 Benefits and Limitations

109.2.1 Federal Eligibility Requirements

As required by 42 CFR 460.150, an individual shall meet the following basic requirements to be eligible to enroll in PACE:

- be 55 years or older
- reside in an approved PACE service area
- meet the state's Medicaid criteria for nursing facility level of care, and
- meet any additional program specific eligibility conditions imposed under the PACE program agreement, including the individual shall be safely served in the community

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Medical Eligibility

The Medicaid Agency has delegated authority for initial and annual level of care determination to the PACE provider. Medicaid eligibility for PACE is based on current admission criteria for nursing facility care. Admission criteria are described in *Chapter 26, Nursing Facility, of the Alabama Medicaid Provider Manual and in the Alabama Medicaid Administrative Code, Chapter 10, 560-X-10-.10.* As the Operating Agency and State Administering Agency for PACE, Alabama Medicaid Agency (AMA) maintains ultimate authority and oversight of this process. AMA will prospectively review all initial and annual redetermination admission level of care determinations for certification before the participant is enrolled/continues to be enrolled in the PACE program. Redetermination of the participant eligibility follows the same procedure as a new enrollment.

NOTE:

Initial enrollment in PACE and annual redetermination requires that the patient meet two criteria listed on PACE Form 12-001 (a-k). As a result, an individual who meets one or more ADL deficits under (k) must also meet an additional criterion from the list (a-j). All assessments submitted for PACE must include supporting documentation. Four exceptions are noted:

- Criterion (a) and criterion (k)-7 are the same as they both involve medication administration. Only one may be used. Therefore, if an individual meets criterion (a), criterion (k)-7 may not be used as the second qualifying criterion.
- Criterion (g) and Criterion (k)-9 are the same as they both involve direction by a registered nurse. Only one may be used. Therefore, if an individual meets criterion (g), Criterion (k)-9 may not be used as the second qualifying criterion.
- Criterion (k) (3) cannot be used as a second criterion if used in conjunction with criterion (d) if the ONLY stoma (opening) is a Gastrostomy or PEG tube.
- Criterion (k) (4) cannot be counted as a second criterion if used in conjunction with criterion (d) if used for colostomy or ileostomy.

NOTE:

If an individual has a serious mental illness or has an intellectual disability, the individual will not be eligible for PACE unless the individual has medical needs unrelated to the diagnosis of serious mental illness or intellectual disability and meets the criteria as set in Chapter 26, Nursing Facility, of the Alabama Medicaid Provider Manual.

ocess for admission includes medical and financial eligibility determination:

- In accordance with 42 CFR 460.152(a) (3), prior to enrollment in PACE, Medicaid shall certify that the PACE applicant meets the state's nursing facility level of care criteria.

- The PACE organization shall submit the level of care screening tool each year to verify that the enrollee continues to meet nursing facility level of care requirements as required in 42 CFR 460.160 (b).

- The determination of level of care will be made by an RN of the PACE organization (PO), certification signed by the PO physician and forwarded on to the AMA PACE Unit RN. This is done prior to submission of Form 204/205 and Form 376. The Form 204/205 and Form 376 are to be mailed to the AMA PACE Unit RN. The PACE Unit RN will complete the Form 376 when the LOC has been approved and will then forward Form 204/205 along with Form 376 to the appropriate Eligibility staff. For

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cases in which medical eligibility cannot be determined by the PACE Unit RN, the documents will be submitted to the Director of Long Term Care for a determination to be made. For cases in which the Director is unable to make a determination, the documents will be submitted to the Alabama Medicaid Agency physician who will review and assess the documentation submitted.

- The earliest date of entitlement for Medicaid is the first day of the month of application for assistance, provided the individual meets all factors of eligibility for that month. The individual who is eligible on the first day of the month is entitled to Medicaid for the full month. It is the responsibility of the PO to verify Medicaid eligibility for participants on a monthly basis. There will be no retroactive benefits applied to initial enrollments in PACE.
- Financial determination is made by the Alabama Medicaid Agency, or the Social Security Administration (SSA). Upon determination of financial and medical eligibility the PO will submit required data electronically via the LTC software to Medicaid's fiscal agent to document dates of service to be added to the Level of Care file. Financial eligibility will be established in accordance with the *Alabama Medicaid Agency Administrative Code, Chapter 25.*

All PACE organizations are required to accurately complete and maintain the following documents related to level of care in the participants file (EMR) for Medicaid/CMS retrospective reviews.

- PACE Form 12-001. A written assessment used to determine a participant's current care needs. This assessment is used to assess each individual participant's functional, medical, social, environmental and behavioral status. Information obtained should be adequate enough to make a level of care decision with supporting documentation for all criteria selected. If criterion G, unstable medical condition is one of the established medical needs, the provider must maintain supporting documentation of the unstable condition requiring active treatment in the 90 days preceding enrollment.
- IDT assessments
- Plan of Care
- Any and all documentation that would support the Level of Care criteria selected on PACE Form 12-001.

Financial Eligibility

Eligibility for enrollment in PACE is not restricted to an individual who is either a Medicaid recipient or a Medicare beneficiary. Individual's eligible for enrolling in the PACE program are those included in one of the categories listed below:

- Eligible for full Medicaid;
- Eligible for Medicare Part A;
- Enrolled under Medicare Part B;
- Dual eligibles for Medicaid and Medicare

Financial determinations are made by the Alabama Medicaid Agency, or the Social Security Administration (SSA), as appropriate.

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Recipients can have Medicare, Medicaid, be dually eligible for Medicare/Medicaid or disabled with income not greater than 300% of the SSI Federal Benefit Rate.

Medicaid does not guarantee future eligibility. For this reason it is very important that providers must verify recipient eligibility on a monthly basis prior to providing a service. For more information refer to Chapter 3, Verifying Recipient Eligibility in the *Alabama Medicaid Provider Manual.*

Enrollment Denials

For any enrollment denial based on level of care, Alabama Medicaid will advise the PO in writing of its decision and the opportunity to request reconsideration of the decision via an Informal Conference so that they may present further information to establish medical eligibility. To request the Informal Conference the PO must submit a letter within 30 days of the date of the letter. This letter must specify the findings that are contested and the basis for the contention. This letter should be addressed to Alabama Medicaid Agency, PACE Program Unit, P.O. Box 5624, Montgomery, AL 36103-5624.

If the Informal Conference results in an adverse decision, the PO is advised of the right to a Fair Hearing. To request the Fair Hearing the PO must submit a letter within 60 days of the date of the letter. This letter should be addressed to Alabama Medicaid Agency, PACE Program Unit, P.O. Box 5624, Montgomery, AL 36103-5624. If the Informal Conference results in a favorable decision, the enrollment procedures are followed.

Prior Approval

Prior approval of the medical level of care must be determined by AMA Medical Review staff. Documentation in support of the Level of Care and PACE Form 12-001 must be submitted to AMA PACE staff. An approval/denial will be faxed to the PACE provider within five working days of receipt of the request. The medical Level of Care must be approved prior to a financial determination. Refer to section 109.6 for additional information regarding PACE assessment requirements.

Enrollment Requirements

- When the participant meets the eligibility requirements and wants to enroll, he/she shall sign an Enrollment Agreement that contains the minimal information under 42 CFR 460.154
- The PACE organization must give a participant, upon signing the enrollment agreement, all of the information set forth in 42 CFR 460.156
- In accordance with 42 CFR 460.158, a participant's enrollment in the program is effective on the first day of the calendar month following the date the PACE organization receives the signed Enrollment Agreement
- In accordance with 42 CFR 460.160, the PACE enrollment continues until the participant's death, regardless of changes in health status, unless the participant voluntarily disenrolls in accordance with 42 CFR 460.162, or is involuntarily disenrolled in accordance with 42 CFR 460.164
- As indicated in 42 CFR 460.154 (p), each individual enrolling in PACE shall accept PACE as his or her sole source for services. This requirement must be included in the PACE Enrollment Agreement and the individual or legally responsible person must acknowledge acceptance of this requirement by signing a form approved by AMA

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NOTE:

If a recipient is enrolled in a HCBS waiver program or receiving nursing facility services or the PO must contact the appropriate operating agency or Alabama Medicaid staff for the associated program well enough in advance of the effective enrollment date in PACE, in order to allow enough time for the process of end dating the other benefit plan segment. If not done, this could delay enrollment of the recipient until the next calendar month.

Initial Level of Care Review

In accordance with 42 CFR 460.152 (a) (3) and as described above, prior to enrollment in PACE, Medicaid shall certify that the PACE applicant meets the state's nursing facility level of care criteria.

Annual Level of Care Review

The PACE organization shall submit the level of care screening tool each year to verify that the enrollee continues to meet nursing facility level of care requirements as required in 42 CFR 460.160 (b). The PACE Organization will submit documents to AMA for redetermination review up to 45 days before the annual date but no later than the 15th of the month before the annual date.

Physical, Functional and Psychosocial Assessment/Plan of Care

Following certification by Medicaid that an eligible recipient meets nursing facility level of care requirements, the PACE interdisciplinary team (IDT), under the direction of the PACE medical director and in accordance with 42 CFR 460.104, must conduct a comprehensive assessment of the participant. The IDT must meet the following assessment requirements:

- An initial in-person comprehensive assessment must be completed promptly following enrollment by the:
  - Primary Care Physician
  - Registered Nurse
  - Social Worker
  - Physical therapist
  - Occupational therapist
  - Recreational therapist or activity coordinator
  - Dietician; and
  - Home care coordinator

- At least semi-annually, an in-person assessment and treatment plan must be completed by the:
  - Primary care physician
  - Registered nurse
  - Social worker

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  - Recreational therapist/activity coordinator and
  - Other team members actively involved in the development or implementation of the participant's plan of care (e.g., home care coordinator, PT, OT or dietitian

- Annually, an in-person assessment and treatment plan must be completed by the:
  - Physical therapist
  - Occupational therapist
  - Dietician and
  - Home care coordinator

Following the required assessments, the PACE program must develop a plan of care for each participant as required by 42 CFR 460.106. PACE organizations consolidate discipline specific plans into a single plan of care semi-annually through discussion and consensus of the IDT. The consolidated plan is then discussed and finalized with the PACE participant and/or his or her significant others.

Reassessments and treatment plan changes are completed when the health or psychosocial situation of the participant changes.

Reference Alabama Medicaid Agency Administrative Code Chapter 53, section 560-X-53-.07 for Participant Assessment and Plan of Care policy provisions.

Signature Requirement

Under Alabama's Uniform Electronic Transactions Act, effective January 1, 2002, Alabama law recognizes the validity of electronic signatures. For all Medicaid PACE Forms, the signature must be an original signature or an approved electronic signature of the recipient's attending physician/PACE physician. Provider certification is made via standardized electronic protocol.

Health and Safety Assessment

The primary consideration underlying the provision of services and assistance to this state's frail and elderly is their desire to reside in a community setting. However, enrollment in a Program of All Inclusive Care for the Elderly may be denied based upon the inability of the program to ensure the health, safety, and well-being of the individual under any of the following circumstances, based on assessment of the individual's mental, psychosocial and physical condition and functional capabilities:

- The individual is considered to be unsafe when left alone, with or without a Personal Emergency Response System
- The individual lacks the support of a willing and capable caregiver who must provide adequate care to ensure the health, safety and well-being of the individual during any hours when PACE services are not being provided
- The individual's needs cannot be supported by the system of services that is currently available
- The individual's residence is not reasonably considered to be habitable

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- The individual's residence or residential environment is unsafe to the extent that it would reasonably be expected to endanger the health and safety of the individual, the individual's caregivers, or the PACE Organization's staff if PACE services are to be provided in the residence
- The individual's behavior is disruptive or threatening or is otherwise harmful (e.g., suicidal, injurious to self or others, or destructive of environment)
- There is a high risk or an existing condition of abuse, neglect or exploitation as evidenced by an assessment

The PACE program shall conduct a comprehensive health and safety assessment to ensure that the applicant's health, safety or welfare will not be jeopardized by living in the community. The assessment must include:

- An on-site evaluation of the applicants residence
- An evaluation of the applicant's social support system, including the willingness and capabilities of all informal caregivers; and
- An evaluation of whether the applicant can be safely transported to the PACE center

PACE Participant Rights

A PACE organization must have a written participant bill of rights designed to protect and promote the rights of each participant. Those rights include, at a minimum, the ones specified in 42 CFR 460.112:

- Respect and nondiscrimination
- Information disclosure
- Choice of providers within the PACE organization's network
- Access to emergency services
- Participation in treatment decisions
- Confidentiality of health information
- Complaints and appeals

Services

The PACE services for all participants, regardless of the source of payment, must include items and services as indicated under 42 CFR 460.90, 42 CFR 460.92 and 42 CFR 490.94 and Alabama Medicaid Agency Administrative Code, section 560-X-53.06.

Provision of Service

- As required by 42 CFR 460.32(a) (1), the PACE program must define its service area. The service area must be approved by AMA and CMS.
- As defined by 42 CFR 460.98(c), the minimum services that must be furnished at each PACE program include primary care, including physician and nursing services; social services, restorative therapies, including physical therapy and occupational therapy, personal care and supportive services, nutritional counseling, recreational therapy and meals, which serve as the focal point for coordination and provision of most PACE services.

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- The PACE program must establish an interdisciplinary team (IDT) to provide care and case manage all of the services provided or arranged by the PACE program for each participant. The IDT must be composed of at least the following members:
    a) Primary care physician
    b) Registered Nurse
    c) Master's-level social worker
    d) Physical therapist
    e) Occupational therapist
    f) Recreational therapist or activity coordinator
    g) Dietician
    h) PACE center manager
    i) Home care coordinator
    j) Personal care attendant or his/her representative; and
    k) Driver or his/her representative

In-Home and Referral Services

As required by 42 CFR 460.94, the PACE program must arrange for all in-home and referral services that may be required for each participant. In-home and referral services are furnished by a PACE organization or by a contracted provider with the PACE program in the manner as set forth in 42 CFR 460.70 and in compliance with 460.71.

Emergency Care Services

The PACE program must provide emergency care services in accordance with 42 CFR 460.100.

An emergency medical condition means a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

- Serious jeopardy to the health of the participant
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

Emergency Services Care Plan

The PACE program must establish and maintain a written plan to handle emergency care at the PACE center and when the PACE participant is not at the PACE center. The plan must include procedures to access emergency care both in and out of the PACE service area. The PACE program must ensure that participants and caregivers know when and how to access emergency care services when not at the PACE center. The plan must ensure that CMS, AMA, and PACE participants are held harmless if the PACE Organization does not pay for emergency services.

Access to Emergency Care

In the case of an emergency medical condition, the PACE participant has the right to access the closest and most readily accessible qualified provider, in or out of the PACE service area, including hospital emergency room services.

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Out-of-Service-Area Emergency Care

Emergency care while the PACE participant is out of the service area is covered by the PACE program and no prior approval is required.

Out-of-Service-Area Follow-up Care

Urgent care and care furnished to the PACE participant to stabilize his or her emergency medical condition that is provided outside the PACE service area must be prior approved by the PACE program.

Retrospective Reviews of Emergency Care

Evaluation of the participant's decision to use emergency services must be based on the prudent layperson standard and no higher standard may be adopted by the PACE program.

Cost of Emergency Care

Charges for all emergency care must be paid by the PACE program.

109.3 Participant Disenrollment from PACE

Voluntary Disenrollment

In accordance with 42 CFR 460.162, a PACE participant may voluntarily disenroll from PACE at any time without cause. The disenrollment date will not be effective until the participant is appropriately reinstated into other Medicaid programs and alternative services are arranged.

The PO is to notify AMA in writing by the 10th of each month of any voluntary disenrollments for the previous month. A copy of the request to voluntarily disenroll is to be submitted with the monthly report. Voluntary disenrollments are to also be reported on quarterly reports submitted to CMS and AMA.

Involuntary Disenrollment

A PACE participant may be involuntarily disenrolled for any of the following reasons established in 42 CFR 460.164:

- Failure to Pay: Any participant who fails to pay, or make satisfactory arrangements to pay any premiums due, to the PACE organization after a thirty-day grace period
- Disruptive or Threatening Behavior: A participant engages in disruptive or threatening behavior. Such behavior is defined as the following:
  - Behavior that jeopardizes the participant's own health or safety, or the safety of others; or a participant with decision-making capacity who consistently refuses to comply with his/her individual plan of care or the terms of the PACE enrollment agreement. Note that a PACE organization may not involuntarily disenroll a PACE participant on the grounds that the participant has engaged in noncompliant behavior related to an existing mental or physical condition unless the participant's behavior is jeopardizing his/her health or safety or that of others. Noncompliant behavior includes repeated noncompliance with medical advice and repeated failure to keep appointments

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- Relocation out of the service area: The participant moves out of the PACE program service area or is out of the service area for more than 30 consecutive days, unless the PACE organization agrees to a longer absence due to extenuating circumstances
- Non-renewal or Termination of Program Agreement: The PACE organization's program agreement with CMS and AMA is not renewed or is terminated
- The participant is determined to no longer meet the Medicaid's nursing facility level of care requirements and is not deemed eligible

Procedures for Involuntary Disenrollment

In the event that a participant is involuntarily disenrolled, the PACE organization shall comply with 42 CFR 460.164.

To involuntarily disenroll a participant, the PACE Organization must obtain the prior review and approval of AMA. The request to disenroll a participant and documentation to support the request must be sent to the AMA PACE Unit. The request and corresponding documentation will be reviewed and a final determination will be made regarding the appropriateness of the involuntary disenrollment. AMA will notify the PACE Organization of approval or denial of the involuntary disenrollment in writing.

The PACE organization must assist the individual in obtaining other care and services to meet his/her medical, functional, psychological, social and personal care needs.

The PO is to notify AMA in writing by the 10th of each month of any completed involuntary disenrollments for the previous month. Involuntary disenrollments are to also be reported on quarterly reports submitted to CMS and AMA.

Effective Date of Disenrollment

The PACE organization is required to ensure that the disenrollment date is coordinated between Medicare and Medicaid for participants who are dually eligible (42 CFR 460.166).

The PACE participant must continue to use and the PACE organization must continue to provide, PACE services up to the effective date of termination (42 CFR 460.166)

The disenrollment date must not become effective until the participant is appropriately reinstated into other Medicare and Medicaid programs and alternative services are arranged (42 CFR 460.168)

Fiscal Agent Enrollment/Disenrollment Notification

When there is both medical and financial approval, the enrollment date will be entered through the Long Term Care (LTC) notification software by the PACE provider. This software enables the provider to submit LTC enrollment/disenrollment notifications on behalf of PACE participants. Enrollment must be completed by the end of the month prior to the effective date for PACE. Example: participant enrolling effective March 1st must have the enrollment information entered in the LTC software program by February 28th. The system is set to automatically default to the first of the following month and PACE providers are not authorized to backdate.

Participants disenrolled from the PACE program must have disenrollment information submitted using the LTC Admission Notification Software within 48 hours. This would include disenrollment due to death, termination from the program or transfer to a Medicaid Waiver program.

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Alabama LTC Admission Notification software is available at no charge to Alabama Medicaid providers. It provides installation procedures and a contact number for the Gainwell Electronic Media Claims (EMC) Help Desk, whose commitment is to assist Alabama Medicaid providers with electronic eligibility, claims, and medical eligibility application submission. Access to the LTC Admission Notification Manual can be done via the Alabama Medicaid web page at the following link:

http://medicaid.alabama.gov/content/7.0_Providers/7.6_Manuals.aspx and/or the Alabama Medicaid Provider Portal (https://www.medicaid.alabamaservices.org/alportal) by navigating to “Information” and click on “AL Links”.

For additional support or questions contact the *EMC Helpdesk at-1-800-456-1242.*

109.4 Additional Requirements

Compliance

Providers shall comply with all applicable federal, state and local laws and regulations, including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements.

Reports to AMA

A PACE Organization is responsible for collecting data, maintaining records, and submitting reports as required by CMS and AMA as outlined in 42 CFR 460, Subpart L. Quarterly reports are to be submitted to CMS through the HPMS system. A copy of the quarterly reports is to be submitted to AMA by secure email. Monthly reports for voluntary and involuntary disenrollments are to be submitted to AMA by secure email. AMA will notify the PACE Organization in writing if it is determined that additional information, or additional reports, are needed.

The following quarterly reports must be submitted to AMA by the 20th of the month following the end of the quarter:

- Routine Immunizations
- Grievances
- Appeals
- Enrollments
- Disenrollments
- Prospective Enrollees
- Readmissions
- Emergency (unscheduled) Care
- Unusual Incidents
- Participant Deaths

Quality Assessment and Performance Improvement Program

The PACE program must develop, implement, maintain, and evaluate an effective data-driven quality assessment and performance improvement (QAPI) program, with the minimum requirements as under 42 CFR 460.134.

AMA will conduct site visits annually in conjunction with CMS, or as needed, to review the quality of service provision by the PACE Organization. The annual site visit review will include a clinical and administrative component and a review of compliance with life safety codes.

Medical Record Documentation

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Per 42 CFR 460.210(b) the PACE organization must maintain a single comprehensive medical record for each participant. The medical record shall contain the following:

- Appropriate identifying information
- Documentation of all services furnished, including the following:
    - A summary of emergency care and other inpatient or long-term care services
    - Services furnished by employees of the PACE center
    - Services furnished by contractors and their reports
- Interdisciplinary assessments, reassessments, plans of care, treatment, and progress notes that include the participant's response to treatment
- Laboratory, radiological and other test reports
- Medication records
- Hospital discharge summaries, if applicable
- Reports of contact with informal support (e.g., caregiver, legal guardian or next of kin)
- Enrollment Agreement
- Physician orders
- Discharge summary and disenrollment justification, if applicable
- Advance Directives, if applicable
- A signed release permitting disclosure of personal information.

Medical Record Retention

In accordance with 42 DFR 460.200, medical records must be maintained in an accessible location for at least six years after the last entry or six years after the date of disenrollment. The records must be available upon request for audit by an authorized representative of the Alabama Medicaid Agency, the state Medicaid Fraud Control Unit and representatives of CMS.

109.5 Capitated Payment and Amounts

The state provides a monthly capitated payment for each PACE participant who is eligible for Medicaid assistance, in accordance with 42 CFR 460.180. The capitation payment amount is specified in the PACE program agreement and is based on the amount AMA would otherwise have paid under the state plan if the recipients were not enrolled in PACE. The capitation payment must be accepted in full for Medicaid participants. The PACE Organization may not bill, charge, collect or receive any other form of payment for the participant unless based on the exceptions listed in 42 CFR 460.182(c).

Payment for Medicare and Medicaid Dually Eligible Recipients

In accordance with 42 CFR 460.180 and 42 CFR 460.182, a PACE program is eligible to receive monthly capitated payments from Medicaid for recipients who are Medicaid eligible or dually eligible for both Medicare and Medicaid when:

- The organization has been approved by AMA as a PACE provider
- The organization has been approved by CMS as a PACE provider; and
- All parties have properly executed the three-way agreement between CMS, AMA and the PACE organization

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Private Pay Participants

Federal regulations (42 CFR 460.186) allow the PACE organization to accept private-pay participants and to collect a premium from individuals who are Medicare-only beneficiaries. A PACE organization may not charge a private pay participant an amount greater than the Medicaid capitated payment amount.

109.6 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers are required to bill Medicaid claims electronically.

PACE providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claims correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

The PACE Organization will use the following procedure codes:

- T1015 for Dual Eligible PACE participants in the community
- T1015 with modifier TF for PACE participants in the nursing facility
- T1015 with modifier TG for Medicaid only PACE Participants in the community

The date of service should be the first day of the month and only one unit should be entered.

109.7 Cost Sharing (Copayment)

Copayment does not apply to services provided by PACE providers.

109.8 Time-Limit for Filing for payment

Medicaid requires all claims for PACE to be filed within one year of the date of service. Refer to Section 5.1.5, Filing Limits and Approved Exceptions, for more information regarding timely filing limits and exceptions.

109.9 Diagnosis Codes

The *International Classification of Diseases*- 10th Revision-*Clinical Modification (*ICD-10-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, AMA Plaza 330 North Wabash Ave, Suite 39300 Chicago, IL 60611-5885, or 1-800-621-8335.

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NOTE:
ICD-9 codes should be used for claims submitted with dates of service prior to or equal to 09/30/2015. ICD-10 codes should be used for claims submitted with dates of service on or after 10/01/2015.

109.10 Place of Service Code

The following place of service code applies when filing claims for PACE:

POS Code	Description
99	Other place of service

109.11 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
CMS-1500 Claim Filing Instructions	Chapter 5
Electronic Media Claims (EMC) Submission	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N
Verifying Recipient Eligibility	Chapter 3

109.12 Resources to learn more about PACE

Code of Federal Regulations
42 CFR Part 460
https://www.govinfo.gov/app/details/CFR-2000-title42-vol3/CFR-2000-title42-vol3-part460

National PACE Association
www.npaonline.org

CMS Website Resources:

CMS PACE Application:
https://www.cms.gov/Medicare/Health-Plans/PACE/Overview

Application Review Guide
https://www.cms.gov/PACE/Downloads/reviewguide.pdf

109.13 CMS PACE Manual

https://www.medicaid.gov/medicaid/long-term-services-supports/program-all-inclusive-care-elderly/index.html

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110 Rehabilitative Services (ASD) – DMH

Rehabilitative Autism Services are specialized medical services delivered by uniquely qualified practitioners designed to treat or rehabilitate persons with Autism Spectrum Disorder (ASD). These services are provided to recipients based on medical necessity guidelines as defined in Chapter 7, Understanding Your Rights and Responsibilities as a Provider.

Direct services can be provided in any home or community setting (except licensed hospital beds) that is convenient for both the recipient and staff member, that affords an adequate therapeutic environment, and that protects the recipient's rights to privacy and confidentiality.

Rehabilitative services will be provided to Medicaid recipients based on medical necessity. Although limits are provided for guidance, the limitation(s) noted can be exceeded based on the individual recipient needs. While it is recognized that involvement of the family in the treatment of individuals with ASD is necessary and appropriate, provision of services where the family is involved clearly must be directed to meeting the identified recipient's treatment needs. Services provided to non-Medicaid eligible family members independent of meeting the identified recipient's treatment needs are not covered by Medicaid. An asterisk denoting this restriction will appear in each service description that refers to a recipient's collateral defined as a family member, legal guardian or significant other.

The policy provisions for rehabilitative services providers can be found in the *Alabama Medicaid Agency Administrative Code*, Chapter 47.

For those providers seeking to render ABA Therapy services, please refer to Chapter 37 Therapy (Occupational, Physical, Speech and ABA).

Intensive Care Coordination is an integral part of Autism Services. See Chapter 106 addressing Targeted Case Management for Autism Spectrum Disorder (Target 3 or 10).

110.1 Enrollment

The Alabama Department of Mental Health (ADMH) enrolls Rehabilitative Autism Services providers and issues provider contracts to applicants who meet the licensure and/or credentialing requirements of ADMH and the State of Alabama, the Code of Federal Regulations (CFR), and the *Alabama Medicaid Agency Administrative Code*.

Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

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Federal requirements mandate providers re-validate periodically with the Alabama Medicaid program (through ADMH). Providers will be notified when they are scheduled to re-validate. Failure to re-validate and provide appropriate documentation to complete enrollment will result in an end-date being placed on the provider file. Once a provider file has been closed for failure to timely re-validate, providers will have to submit a new application for enrollment.

National Provider Identifier, Type, and Specialty

A provider who has a contractual agreement with ADMH as an Autism Services provider is added to the Medicaid system with the National Provider Identifiers provided at the time application is made. Appropriate provider specialty codes are assigned to enable the provider to submit requests and receive reimbursement for Autism Services-related claims.

NOTE:
The 10-digit NPI is required when filing a claim.

Rehabilitative services providers are assigned a provider type of 11 (State Rehabilitative Services). The valid specialties for Rehabilitative Autism Services are:

- Rehabilitative Autism Services - DMH (114)

Enrollment Policy for Rehabilitative Services Providers

Autism Services providers must complete the Autism Services applications and submit to ADMH, along with proof of licensure/certification, transcript, and work experience.
To participate in the Alabama Medicaid Program, Rehabilitative Autism Services providers must meet the following requirements. Service providers must demonstrate that they meet the criteria in either (1) or (2), and (3) below.

1. A provider must have demonstrated the capacity to provide access to the following services through direct provision:
    - Must submit an application to and receive approval by ADMH to provide Rehabilitative Autism Services for children under age 21 under the Medicaid Rehabilitative Option program if they have demonstrated capacity to provide medically necessary services, either directly or through contract.

2. A provider must demonstrate the capacity to provide services off-site in a manner that assures the recipient'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 services delivered in a flexible manner to best meet their needs.

110.1.1 Minimum Qualifications for Rehabilitative Autism Service Professional Staff

Providers are qualified personnel who provide services within home or community, and who provide services guided by an Individualized Service Plan (ISP). Providers must meet recognized standards under Autism Services and include the following disciplines, at a minimum:

- Physician

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- Psychologists
- Licensed Professional Counselors
- Licensed Marriage and Family Therapists
- Licensed Social Workers
- Behavior Therapists (BCBA, BCBA-D, Psychologist)
- Behavior Support Monitors (RBT, BCaBA, Behavior Therapist, SLP, LPC)
- Speech Pathologists
- Occupational Therapists
- Physical Therapists
- Registered Nurses
- Child/Youth Peer Support Specialists
- Family Peer Support Specialists
- Therapeutic Mentors

A Professional Autism Services Specialist (PASS) I is defined as the following:

- An individual licensed in the State of Alabama as a
  - Physician
  - Clinical Psychologist
  - Professional Counselor
  - Marriage and Family Therapist
  - Graduate Level Social Worker
  - Registered Nurse

OR

  - An individual who has a Master's Degree or above from a nationally or regionally accredited university or college in psychology, counseling, social work, or other behavioral health area with requisite course work equivalent to that degree in counseling, psychology, or social work.

A Professional Autism Services Specialist (PASS) II is defined as the following:

- Individual who has a Bachelor of Arts or Bachelor of Science in a human services related field from an accredited college or university with a minimum of one-year experience working with individuals with disabilities, families and/or service coordination

A Certified Autism Support Specialist (CASS) is defined as the following:

- A person with an Associate's degree or high school diploma or GED supervised by a Professional Autism Services Specialist I.
- A Parent Autism Peer Support Specialist provider who is parenting or has parented a child with ASD and can articulate the understanding of their experience with another parent or family member. This individual may be a birth parent, adoptive parent, family member standing in for an absent parent, or other person chosen by the family or youth to have the role of parent. This individual has at least a high school diploma or GED and has satisfactorily completed an Autism Parent Peer Support Provider training program approved by state. A Parent Autism Peer Support Specialist must be supervised by a Professional Autism Services Specialist I.
- A Youth Autism Peer Support Specialist must be 18 years of age or older and serves children and youth ages 0-21 and uses his/her life experience with ASD and specialized training to promote resiliency. Youth Autism Peer Support service can be provided in an individual, family, or group setting by a Certified Child/Youth Autism

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Peer Support Specialist. A Child/Youth Peer Support Specialist must be supervised by PASS I. This individual has satisfactorily completed a Youth Autism Peer Support Provider training program approved by the state.

110.2 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 Chapter 7, Understanding Your Rights and Responsibilities as a Provider, for general criteria on Medical Necessity/ Medically Necessary Care.

Treatment eligibility is limited to individuals with a diagnosis of F84.0, F84.1, F84.5, and F84.9, assigned by a licensed physician or a licensed psychologist as listed in the most current International Classification of Diseases - 10th Revision - Clinical Modification (ICD-10-CM).

110.2.1 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 must be directed to meeting the recipient's treatment needs. Medicaid does not cover services for non-Medicaid eligible family members independent of meeting the recipient's treatment needs.

Only the following rehabilitative services qualify for reimbursement under this program:

- Behavior Support
- In Home Therapy (Mental Health Support)
- Mental Health Care Coordination
- Peer Support
- Psychoeducational Services
- Therapeutic Mentoring

Intensive Care Coordination is an integral part of Autism Services. All providers must participate in the development of the Individualized Service Plan (ISP). All services must be provided as outlined on the ISP. Refer to Chapter 106 addressing Targeted Case Management for Autism Spectrum Disorder (Target 3 or 10).

The ISP teams are usually comprised of the child/youth, Intensive Care Coordinator, parents/family members, and other service providers as they relate to the identified needs of the child/youth. The team will establish a written ISP. The ISP team then implements this plan.
An ISP is required for each child/youth and ICC personnel is responsible for assisting eligible children/youth in gaining access to needed medical, social, therapeutic, educational, and other services and is responsible for initiating and guiding those service interventions.

This section contains a complete description of each covered service along with benefit limitations.

The following is a description of each ASD service. Please see ASD Services Grid for Billing Unit, Daily Maximum Units, and Billing Restrictions.

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The following procedure codes apply when filing claims for ASD Rehabilitative Services. The (837) Professional and Institutional electronic claims and the paper claim have been modified to accept up to four procedure code modifiers.

Claims without procedure codes or with invalid codes will be denied. Only the procedure codes listed in this section are covered under this program.

HCPCS Code	***Description***	***Daily Max***	***Annual Max Units***
H2019	Behavior Support	16	4160
T1027	In Home Therapy (Mental Health Support)	8	832
H0046	Mental Health Care Coordination	24	312
H0038	Peer Support – Family Individual Group	 20 20	 2080 2080
H0038	Peer Support – Youth Individual Group	 20 20	 2080 2080
H2027	Psychoeducational Services Individual Group	 8 8	 416 416
H2014	Therapeutic Mentoring Individual Group	 8 8	 416 416

Telehealth Billing Guidelines

Refer to Chapter 112, Telemedicine Services, for general benefit information and limitations.

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Behavior Support (H2019)

Positive behavior support therapy and monitoring is designed to address challenging behaviors in the home and community for children and youth with ASD or ASD with co-occurring IDD. A behavioral therapist writes and monitors a behavioral management plan that includes specific behavioral objectives and interventions that are designed to diminish, extinguish, or improve specific behaviors related to the child's or youth's behavioral health condition. The behavioral therapist supervises and coordinates the interventions and trains others who works with the family to implement the plan in the home and in the community.

Eligible Provider Type:

Behavior Support services may be performed by a person who possesses any one or more of the following qualifications:

Behavior Therapist:

- A Professional Autism Services Specialist I (PASS I) who is
    - Licensed and Board Certified Behavior Analyst (BCBA, BCBA-D, LBA) OR Licensed Psychologist, AND
    - Possesses at least two years full-time working experience in providing services to individuals with ASD, one year of which much be post-graduate work.

Behavior Support Monitor:

- PASS I who qualifies as at least one of the following:
    - Licensed and Board Certified Assistant Behavior Analyst (BCaBA, LABA)
    - Registered Behavior Technician
    - Licensed Professional Counselor (LPC)
    - Licensed Speech Pathologist (SLP)
    - Licensed Occupational Therapist (OT)
    - Licensed Clinical Social Worker (LCSW)

    AND

    - Possesses at least two years full-time working experience in providing services to individuals with ASD, one year of which much be post-graduate work.

- A **Professional Autism Services Specialist II** (PASS II) who qualifies as at least one of the following:
    - A Bachelor degree in a relevant human services field and the appropriate training in implementing behavioral interventions, including: Licensed & Board Certified Assistant Behavior Analyst (BCaBA, LABA), Registered Behavior Technician (RBT)
      AND
    - Minimum one-year of supervised experience in performing ASD services after obtaining the degree.

- A **Certified Autism Support Specialist** (CASS) who qualifies as:
    - High-school diploma or GED, and
    - Registered Behavior Technician Certification, and
    - Minimum two years' experience working with children/adolescents/transition-age youth, and adequate ongoing supervision.

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Key service functions include the following:

- Discrete Trial Training- PASS I, PASS II, CASS
- Incidental Teaching- PASS I, PASS II, CASS
- Pivotal Response Training- PASS I, PASS II, CASS
- Verbal Behavior Intervention- PASS I, PASS II, CASS
- Functional Communication Training- PASS I, PASS II, CASS
- Coping Skills Training- PASS I, PASS II, CASS
- Assessment- PASS I, PASS II
- Reduction of Environmental Barriers to Learning- PASS I, PASS II, CASS
- Maladaptive Behavior Reduction- PASS I, PASS II, CASS
- Functional Behavior Assessment- PASS I, PASS II
- Functional Analysis- PASS I
- Crisis Intervention- PASS I, PASS II
- Social Skills Therapy- PASS I, PASS II, CASS
- Psycho-educational Services- PASS I, PASS II, CASS
- Sensory Integration- PASS I, PASS II, CASS
- Development of Individual Program Plan- PASS I
- Progress Reporting- PASS I
- Transition Planning- PASS I
- Family Training- PASS I, PASS II, CASS
- Augmentative Communication Training- PASS I, PASS II, CASS

Billing Unit: 15 minutes

Maximum Units: 16 units/day; 4,160 units/year (1040 hours annually)

Billing Restrictions: 97151 Behavior Identification Assessment, 97152 Observational F/U assessment, 0362T Exposure Behavioral F/U assessment, 97153 Adaptive Behavior Treatment, 97154 Group Adaptive Behavior Treatment, 97158 Social Skills Group, 0373T Exposure Adaptive Behavior Treatment, 97155 Adaptive Behavior Modification, 97156 Family Adaptive Behavior Treatment Guidance, 97157 Multiple Family, Group Treatment Guidance

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In Home Therapy (T1027) (Mental Health Support)

Definition

A structured, consistent, strength-based therapeutic relationship between a licensed clinician and a child or youth with ASD or ASD and co-occurring IDD and his or her family for the purpose of treating the child's or youth's behavioral health needs. In-Home Therapy services are provided under a multidisciplinary team model. In Home Therapy also addresses the family's ability to provide effective support for the child or youth and enhances the family's capacity to improve the child's or youth's functioning in the home and community.

Eligible Provider Type:

In Home Therapy services may be performed by a person who possesses any one or more of the following qualifications:

- Professional Autism Services Specialist I (PASS I): (i)An individual licensed in the State of Alabama as a (1) Professional Counselor, Graduate Level Social Worker, Registered Nurse, Marriage and Family Therapist, Clinical Psychologist, Physician; or (ii) An individual who (1) Has a Master's Degree or above from a nationally or regionally accredited university or college in psychology, counseling, social work, or other behavioral health area with requisite course work equivalent to that degree in counseling, psychology, or social work.
- Professional Autism Services Specialist II (PASS II) – An individual who has a Bachelor of Arts or Bachelor of Science in a human service related field from an accredited college or university with a minimum of one-year experience working with individuals with disabilities, families and/or service coordination

Key service functions include the following:

- Psychoeducational Services- PASS I, PASS II
- Individual counseling/therapy- PASS I, PASS II
- Family counseling/therapy- PASS I, PASS II
- Group counseling/therapy- PASS I, PASS II
- Coping Skills Training- PASS I, PASS II
- Assessment- PASS I
- Therapeutic Treatment- PASS I, PASS II
- Crisis Intervention- PASS I, PASS II
- Basic Living Skills- PASS I, PASS II
- Social Skills Therapy- PASS I, PASS II
- Treatment Plan Review- PASS I
- Progress Reporting- PASS I
- Development of Individual Program Plan- PASS I
- Transition Planning- PASS I

Billing Unit: 15 minutes

Maximum Units: 8 units/day; 832 units/year (208 hours annually) 4hrs/week

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Mental Health Care Coordination (H0046)

Definition

Services to assist an identified Medicaid recipient to receive coordinated mental health services from external agencies, providers or independent practitioners.
Key service functions include written or oral interaction in a clinical capacity in order to assist another provider in addressing the specific rehabilitative needs of the recipient, as well as to support continuation of care for the recipient in another setting.

Eligible Provider Type:

- PASS I
- PASS II
- CASS

Billing Unit: 15 minutes

Maximum Units: 24 per day, 312 per year

Additional Information

Acceptable service provision that qualify as Mental Health Care Coordination includes but is not limited to: Telephone or face to face consultation with a contract provider, doctor, therapist, school teacher, school counselor and/or other professional that is working with the child external to your agency regarding the treatment needs of the child.

Inappropriate tasks include: Scheduling/Rescheduling/Canceling appointments, sharing clinical information within your agency/organization, reading reports or case summaries, writing progress notes or reports, receiving information not pertaining to the treatment needs of the child.

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Peer Support (Youth:H0038-HA or HA;HQ Group; Family: H0038-HC or HC:HQ Group)

Definition

Peer Support services provides structured, scheduled activities that promote socialization, self-advocacy, development of natural supports, and maintenance of community living skills, by Certified Peer Specialists. Peer Support service actively engages and empowers an individual and his/her identified supports in leading and directing the design of the service plan and thereby ensures that the plan reflects the needs and preferences of the individual (and family when appropriate) with the goal of active participation in this process. Additionally, this service provides support and coaching interventions to individuals (and family when appropriate) to promote resiliency and healthy lifestyles and to reduce identifiable behavioral health and physical health risks and increase healthy behaviors intended to prevent the onset of disease or lessen the impact of existing chronic health conditions. Peer supports provide effective techniques that focus on the individual's self-management and decision making about healthy choices, which ultimately extend the members' lifespan. Family peer specialists assist children, youth, and families to participate in the wraparound planning process, access services, and navigate complicated adult/child-serving agencies.

Eligible Provider Type:

Family Peer Support services may be performed by a person who possesses the following qualifications:

- A **Parent Autism Peer Support Specialist** provider who is parenting or has parented a child with ASD and can articulate the understanding of his/her experience with another parent or family member. This individual may be a birth parent, adoptive parent, family member standing in for an absent parent, or other person chosen by the family or youth to have the role of parent. This individual has at least a high school diploma or GED, and has satisfactorily completed a Parent Autism Peer Support Provider training program approved by the state. A Parent Autism Peer Support Specialist must be supervised by a Professional Autism Services Specialist I.

Youth Peer Support services may be performed by a person who possesses the following qualifications:

- A **Youth Autism Peer Support Specialist** must be 18 years of age or older and serves children and youth ages 0-21 and uses his/her life experience with ASD and specialized training to promote resiliency. Youth Autism Peer Support service can be provided in an individual, family, or group setting by a Certified Child/Youth Autism Peer Support Specialist. A Child/Youth Peer Support Specialist must be supervised by PASS I. This individual has satisfactorily completed a Youth Autism Peer Support Provider training program approved by the state.

Key service functions include the following:

- Mentoring, advocacy, development of coping/problem solving skills
- Promotion of socialization and development of natural supports
- Engagement of community services

Billing Unit: 15 minutes

Maximum Units: Limited to 20 units per day (individual) and 8 units per day (group). 2,080 units per year for group services and 2,080 units per year for individual services.

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Psychoeducational Services (H2027– Individual; H2027-HQ – Group)

Definition

Structured, topic specific educational services provided to assist the recipient and the families* of recipients in understanding the nature of the identified behavioral health disorder, symptoms, management of the disorder, how to help the recipient be supported in the community and to identify strategies to support restoration of the recipient to his/her best possible level of functioning.

Key service functions include, as appropriate, but are not limited to education about the following:

- The nature of the disorder
- Expected symptoms
- Ways in which the family member can support individuals with the disorder

Eligible Provider Type:

- PASS I
- PASS II
- CASS

Billing Unit: 15 minutes

Maximum Units: 416 per year (416 units per year for individual and 416 units per year for group)

- 8 units (unit = 15 minutes) per day, individual
- 8 units (unit = 15 minutes) per day, group

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Therapeutic Mentoring (H2014– Individual; H2014-HQ – Group)

Definition

Therapeutic Mentoring Services provide a structured one on one intervention to a child or youth and their families that is designed to ameliorate behavioral health-related conditions that prevent age-appropriate social functioning. This service includes supporting and preparing the child or youth in age-appropriate behaviors by restoring daily living, social and communication skills that have been adversely impacted by a behavioral health condition. These services must be delivered according to an individualized treatment plan and progress towards meeting the identified goals must be monitored and communicated regularly to the PASS I so that the treatment plan can be modified as necessary. Therapeutic mentoring may take place in a variety of settings including the home, school or other community settings. The therapeutic mentor does not provide social, educational, recreational or vocational services.

Key service functions include the following:

- Basic Living Skills
- Social Skills Training
- Coping Skills Training
- Assessment
- Plan Review
- Progress Reporting
- Transition Planning

Eligible Provider Type

- PASS I
- PASS II
- CASS

Billing Unit: 15 minutes

Maximum Units: 416 per year (416 units per year for individual and 416 units per year for group)

- 8 units (unit = 15 minutes) per day, individual
- 8 units (unit = 15 minutes) per day, group

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110.2.2 Reimbursement

The Medicaid reimbursement for each service provided by an Autism Rehabilitative Services provider is based on the following criteria and does not exceed the lowest of the following amounts:

- The fee schedule established by Medicaid as the maximum allowable amount
- 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.

110.2.3 Requirements for Recipient Intake, Treatment Planning, and Service Documentation

Once a recipient is determined eligible for Rehabilitative Autism Services, the Intensive Care Coordinator will refer the client to appropriate Rehabilitative Autism Services.

Documentation in the recipient's record for each session, service, or activity for which Medicaid reimbursement is requested must comply with any applicable certification or licensure standards and must include the following, at a minimum:

- The identification of the specific services rendered
- The date and the amount of time that the services were rendered (to include the time started and the time ended)
- 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 recipient's progress, or lack thereof, related to each of the identified clinical issues discussed.

All entries must be legible and complete and must be signed and dated by the person (identified by name **and** discipline) who is responsible for providing the service. The author of each entry must be identified and must sign his or her entry.

Documentation of Medicaid recipients' signatures may be entered on a sign-in log, service receipt, or any other record that can be used to indicate the recipient's signature and the date of service. The recipient's signature is only required one time per day that services are provided. Any non-face-to-face services that can be provided by telephone do not require recipient signatures.

When clinical records are audited, Medicaid will apply the list of required documentation to justify payment. Documentation failing to meet the minimum standards noted above will result in recoupment of payments.

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Additional Information

Documentation

Documentation should not be repetitive (examples include, but are not limited to the following scenarios):

- Progress Notes that look the same for other recipients.
- Progress notes that state the same words day after day with no evidence of progression, maintenance or regression.
- Treatment Plans that look the same for other recipients.
- Treatment Plans with goals and interventions that stay the same and have no progression.

Progress Notes

- Progress Notes should not be ***preprinted*** or predated with the exception that a group therapy note may have a general section that identifies the participants (i.e. the number of participants, etc.), the topic, and a general description of the session which is copied for each participant. However, each participant must also have individualized documentation relative to his/her specific interaction in the group and how it relates to their treatment plan.
- The progress note should match the goals on the plan and the plan should match the needs of the recipient. The interventions should be appropriate to meet the goals. There should be clear continuity between the documentation.
- Progress Notes must provide enough detail and explanation to justify the amount of billing.

Treatment Plan

- The Treatment Plan should not be signed or dated prior to the plan meeting date.

Authentication

- Authors must always compose and sign their own entries (whether handwritten or electronic). An author should never create an entry or sign an entry for someone else or have someone else formulate or sign an entry for them. If utilizing a computer entry system, the program must contain an attestation signature line and time/date entry stamp.
    - If utilizing a computer entry system, there must be a written policy for documentation method in case of computer failure/power outage.

Corrections

- Corrections must be made legally and properly by drawing a line through the entry and making sure that the inaccurate information is still legible. Write “error” by the incorrect entry and initial. Do not obliterate or otherwise alter the original entry by blacking out with marker, using whiteout, or writing over an entry. White Out, Liquid Paper, or any form of correctional fluid or correctional tape is not acceptable on **any** records whether being used as a corrective measure or to individualize an original template or for any other reason.

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110.2.4 Requirements for Supervision/Monitoring and Complaint Procedure for Unlicensed Providers Supervision/Monitoring

In order to regulate the quality of services performed by unlicensed allied mental health providers, all behavioral health services rendered by non-licensed individuals are required to be authorized by and performed under the supervision of a qualified supervisor as determined by ADMH. ADMH must abide by their policy/guidelines that have been developed outlining supervision of unlicensed allied mental health providers who provide ASD Rehabilitative Services.

NOTE: The permitting of unlicensed allied mental health professionals to provide services does not authorize a party to hold themselves out as a licensed professional or as titled professional for which a license is required.

Complaints

Complaints received to the Alabama Medicaid Agency against unlicensed providers will be forwarded to the Alabama Department of Mental Health – Office of Autism Services for investigation. DMH must abide by their policy/guidelines that have been developed outlining complaint investigation procedure and submit a report of findings and actions taken (if any) to the Alabama Medicaid Agency. The Alabama Medicaid Agency may also conduct an investigation in reference to received complaint.

110.2.5 Requirements for Telemedicine Billing

Refer to Chapter 112, Telemedicine Services, for general benefit information and limitations.

110.3 Prior Authorization and Referral Requirements

Rehabilitative services procedure codes generally do not require prior authorization (PA), except for circumstances when a Rehab Option provider determines that it is medically necessary to provide treatment services that goes beyond the indicated service limits for a recipient eligible under EPSDT (under age 21). Medical necessity will be established from the recipient's condition at the time of the request, not the diagnosis alone.

Approval is required if number of service hours will be exceeded for a particular service. All prior approvals of additional Autism Services units require approval from the *Regional Autism Coordinator*. All requests must be received at least **10 days** prior to the anticipated date of need. All approvals for additional units are based on the individual's needs and extraordinary circumstances.

To request additional units, the provider must complete the "Request for Additional Hours" form and submit for review by Intensive Care Coordinator (ICC). The ICC will determine need and approve if appropriate. The client/family should be made aware of request. The ICC should then send to the Regional Autism Coordinator for approval of increase. The Regional Autism Coordinator will determine need and approve if appropriate. The ICC will then be responsible of updating authorization in Therap.

To access the "Request for Additional Hours" form, refer to the ADMH Autism Services website at https://mh.alabama.gov/autism-services/.

Rehabilitative services do not require an ACHN referral.

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110.4 Cost Sharing (Copayment)

Copayment does not apply to rehabilitative services.

110.5 Completing the Claim Form

110.5.1 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.

110.5.2 Diagnosis Codes

The International Classification of Diseases - 10th Revision - Clinical Modification (ICD-10-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, AMA Plaza 330 North Wabash Ave, Suite 39300 Chicago, IL 60611-5885, or 1-800-621-8335.

110.5.3 Procedure Codes and Modifiers

The (837) Professional and Institutional electronic claims and the paper claim have been modified to accept up to four Procedure Code Modifiers. Use the modifiers to distinguish ASD services and individual/group services.

Modifier 59 (Distinct Procedural Service)

Under certain circumstances eligible DMH ASD staff may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier 59 is used to identify procedures/services that are not normally reported together, but are appropriate under the circumstances. This may represent a different session or patient encounter, not ordinarily encountered or performed on the same day by the same eligible DMH ASD staff. However, when another already established modifier is appropriate, it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used.

According to the CPT book, modifier 59 is described as being necessary to describe a distinct procedural service. This modifier should only be used to show a distinct procedural service when a comprehensive/component coding pair is billed. Modifier 59 should not be billed to represent that multiple services of the same procedure code were performed.

A comprehensive/coding pair occurs when one code is considered a component procedure and the other code is considered a comprehensive procedure. These code pairs are frequently referred to as bundled codes thus meaning the component code is usually considered an integral part of the comprehensive code. Therefore, in most instances the most comprehensive code only should be billed and the component code should be denied as re-bundled or mutually exclusive. Modifier 59 should only be used in conjunction with a comprehensive/ coding pair procedure when appropriately unbundling the code pair. This modifier 59 should not be billed with the comprehensive code. The component code can be unbundled or allowed separately, in certain situations. If the two services are performed at two different times of day, then modifier 59 can be submitted with the component procedure code.

In order to communicate the special circumstances of the component/ comprehensive code pair unbundling, diagnoses codes must be utilized as appropriate on the claim form. In some cases, it

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may be necessary to attach a detailed explanation of services rendered to further explain the reason for the unbundling of code pairs.

CMS publishes the National Correct Coding Initiative Coding Policy Manual for Medicare and Medicaid Services (https://www.medicaid.gov/medicaid/program-integrity/national-correct-coding-initiative-medicaid/index.html) and this may be used as a reference for claims-processing edits. The manual is updated annually, and the NCCI edits are updated quarterly. It is the responsibility of the provider to check the site quarterly for any billing related updates.

110.5.4 Place of Service Codes

The following place of service codes apply when filing claims for rehabilitative services:

POS Code	Description
11	Office
12	Home
99	Other Unlisted Facility

***Must document in progress/treatment notes where the POS 99 service occurred.

110.5.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to the following circumstances:

- Claims With Third Party Denials

Refer to Section 5.8, Required Attachments, for more information on attachments.

110.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
CMS-1500 Claim Filing Instructions	Chapter 5, Section 5.2
Medical Medicaid/Medicare-related Claim Filing Instructions	Chapter 5, 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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111

111 Remote Patient Monitoring (RPM)

Remote Patient Monitoring (RPM), also known as In-home Remote Patient Monitoring, is a program that allows medical providers to monitor and manage acute and chronic health conditions while the patient is home. The goal of the program is to decrease exacerbation episodes, emergent care visits, hospital admissions, and medical costs and increase self-management of the disease/chronic condition.

Services rendered by non-physician practitioners, i.e., physician assistants, certified registered nurse practitioner, etc., must adhere to applicable guidelines, policies and procedures. Refer to Administrative Code chapters 6: Physicians and 49: Certified Register Nurse Practitioner (CRNP) for additional information.

111.1 Provider Enrollment

Medicaid's fiscal agent enrolls providers and issues provider contracts to applicants who meet the licensure and/or certification requirements of the State of Alabama, the Code of Federal Regulations, the Alabama Medicaid Agency Administrative Code, and the Alabama Medicaid Provider Manual.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

Federal requirements mandate providers re-validate periodically with the Alabama Medicaid program. Providers will receive a notification when it is time to re-validate. Failure to re-validate and provide appropriate documentation to complete the enrollment process will result in an end-date being placed on the provider file. A new enrollment application must be submitted once a provider file has been closed due to failure to timely re-validate.

111.1.1 *National Provider Identifier, Type, and Specialty*

A provider who contracts with Medicaid as an RPM provider is added to the Medicaid system with the National Provider Identifiers provided to the Agency at the time application is made. Appropriate provider specialty codes are assigned to enable the provider to submit requests and receive reimbursements for RPM-related claims.

NOTE:
The 10-digit NPI is required when filing a claim

Remote Patient Monitoring providers are assigned a provider type of 08 (Remote Patient Monitoring) and provider specialty 085 or 086.

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111.1.2 *Enrollment Policy for RPM Providers*

Any provider that can and is willing to pay the Alabama State Share may enroll as an RPM provider. A Memorandum of Understand (MOU) must be executed between the Medicaid Agency and the RPM provider. The MOU will outline the financial and medical responsibilities for the Medicaid Agency and the RPM provider.

Requirements include but not limited:

- Ability to provide services statewide.
- Meet appropriate clinical staffing requirements.
- Provides and allows the recipients to keep user friendly, interactive audio and video technology monitoring equipment.
- Accepts electronic submissions of referrals.
- Provides an in-home initial assessment.
- Transmits recipient data automatically in real time (a Medicare requirement).
- Reviews, intervenes and reports on the data promptly.
- Provides 24-hour-a-day, 7-day-a-week (24/7) access to physicians or other qualified health care professionals or clinical staff, to address urgent needs of recipients.
- Develops, monitors and updates a patient-centered care plan
- Ongoing, compliance monitoring.
- Program graduation, when appropriate.

Federal requirements mandate providers re-validate periodically with the Alabama Medicaid program. Providers will receive a notification when it is time to re-validate. Failure to re-validate and provide appropriate documentation to complete the enrollment process will result in an end-date being placed on the provider file. A new enrollment application must be submitted once a provider file has been closed due to failure to timely re-validate.

111.1.3 *Provider Termination and/or Change of Ownership*

Medicaid may terminate the RPM provider's participation in the Medicaid program if the provider is participating in cases involving fraud or willful or grossly negligent non-compliance with all applicable program, State and federal guidelines.

Medicaid must be notified in writing within thirty (30) days of the date of an owner and/or name change. The existing contract will be terminated, and a new contract must be signed to continue participation in the Medicaid program.

Please refer to the executed MOU for specific information regarding the termination or expiration of the MOU between the Medicaid Agency and the provider.

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111.2 Benefits and Limitations

Remote Patient Monitoring (RPM) services are available to Medicaid eligible persons with a need for daily monitoring and with a diagnosis of one or more of the following conditions:

- Diabetes
- Gestational Diabetes (effective 10/1/2022)
- Hypertension
- Congestive Heart Failure
- Pediatric Asthma (effective 10/1/2022)

An order from the recipient's primary care physician (PCP) is required prior to the start of rendering RPM service. Orders for RPM, along with the specific parameters for daily monitoring, must be obtained from the patient's PCP prior to evaluation and admission. The order must be documented in the medical record. Orders must be signed and dated by the ordering practitioner and must be obtained annually.

Referrals for RPM may be accepted from any source, including physicians, ACHN Care Coordinators, patient or caregiver, the Health Department, hospitals, home health agencies, or community-based organizations.

A practitioner must obtain patient consent before furnishing or billing RPM services. Consent may be verbal or written but must be documented in the medical record, and includes informing them about:

- The availability of RPM services and applicable cost sharing
- That only one practitioner can furnish and be paid for RPM services during a calendar month
- The right to stop RPM services at any time (effective at the end of the calendar month)

Informed patient consent by the recipient or caregiver, when appropriate, must be obtained prior to rendering RPM services or if the patient chooses to change the practitioner who will render the services.

111.2.1 *Benefits*

Benefits for the RPM program include:

- improved health outcomes for eligible Medicaid recipients
- increased collaboration between PCP and patient/care giver
- teaches the patient and/or care giver self-management of the disease/chronic condition
- reduces hospital admissions and emergency department visits for recipients with identified chronic conditions/diagnoses
- health care monitoring provided in-home that reduces travel and in-person office visits

RPM services include, but are not limited to:

- Initial home assessment for RPM
- Initial setup of RPM equipment
- Instructions and education about the use of monitoring devices
- Instructing the patient/care giver on data entry

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- Instructing patient on optimum symptom control
- Direct patient contact, when necessary and as indicated
- Evaluate threshold violations
- Monitoring and follow up
- Diet/nutrition education
- Needs assessing/screening
- Making referrals for care when appropriate

RPM providers must also develop a process for addressing patient noncompliance. This process should include the expected actions of the patient and the RPM provider related to initial and on-going noncompliance issues. Noncompliance and the specified actions must be documented in the patient's chart.

111.2.2 *Limitations*

Medicaid will not separately reimburse for any direct care services, such as wound care, rendered by RPM providers. RPM services are restricted to the medical diagnosis outlined in section 111.2.

111.3 Documentation Requirements

The RPM provider must maintain complete and accurate medical, case management, and fiscal records that fully disclose the extent of the services provided. All documentation must be legible, signed and dated by the person (identified by name and discipline) who is responsible for ordering, providing, or evaluating the service furnished. Additionally, the author of each entry must sign his or her entry, either handwritten or electronic. A stamped signature is not acceptable. (Signatures must be in compliance with details specified in Administrative Code Rule No. 560-X-1-.18 Provider and Recipient Signature Requirements.)

RPM records must contain documentation of:

a) Name and date of birth of recipient,
b) recipient Medicaid ID,
c) dates of services,
d) initial assessment,
e) initial physician's order and any changes to the physician's order, (All provider's orders must be signed and dated by a licensed nurse)
f) physician order renewals, (All provider's orders must be signed and dated by a licensed nurse)
g) recipient consent for services,
h) diagnoses from qualified Medical Professional,
i) medical history and physical,
j) threshold violations,
k) name of RPM provider and person providing services,
l) nature, start and end time, extent or units of services provided, and
m) a written assessment of the client's progress. (documented in the patient's chart at least monthly until discharge),
n) Initial home assessment for RPM,
o) Initial setup of RPM equipment,
p) Instructions and education on the use of monitoring devices,

Added: (All provider's orders…a licensed nurse)
Added: (All provider's orders…a licensed nurse)

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q) Instructing the patient/ caregiver on data entry,

r) Instructing the patient on optimum symptom control,

Documentation must also include supervision of staff as required by licensing boards and applicable state and federal guidelines.

LPN observation by an RN or RN Supervisor

The RN must review all physician orders that are received by an LPN. The RN or RN supervisor must review the orders for accuracy and completion. After the RN has reviewed the Physician's orders, the RN must sign and date the orders. The RN must document in the patient's chart that the orders were reviewed, are accurate, and complete.

The RN or the RN supervisor must review the patient's chart for documentation completed by an LPN at least monthly. The RN or RN supervisor must document in the patients' chart that the LPN's documentation was reviewed.

The RPM 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.

111.3.1 *Program Evaluation Report*

Program evaluation reports are required at least annually unless otherwise specified. The purpose of the report is to conduct a retrospective review, per calendar year, of relevant patient data and Medicaid claims to evaluate the efficiency of the RPM program. Specifics to be included in the report must include at least the following:

- Patient enrollments and re-enrollments
- Length of time patient enrolled in RPM program
- Number of deceased patients
- Improved patient compliance
- Patient graduation/program completion stats
- Reduced hospital admissions
    - Number of visits
    - Length of stay
    - Average length of stay
    - Total cost
    - Average cost
    - Percent changes
- Reduced emergency department visits
    - Number of visits
    - Average visits
    - Percent changes
- Pharmacy cost impact
- Reduced overall health costs

111.4 Reimbursement

1. Remote Patient Monitoring (RPM) provider may submit a claim to Medicaid once each month

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NOTE: Claims paid in error will be subject to recoupment.

2. The RPM provider agrees to accept payment in full as the amount paid for covered RPM services.

111.4.1 *Completing the Claim Form*

To enhance the effectiveness and efficiency of Medicaid processing, providers are encouraged to bill Medicaid claims electronically.

RPM 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.

111.4.2 *Procedure Codes, Modifiers, and Diagnosis Codes*

Billing Instructions: RPM provider bills on a UB-04 claim form using the following procedure codes, modifiers, and diagnosis codes:

- Revenue Code: 789
- Procedure Code: G9008-U4 (Nurse Case Management)
- Procedure Code: S9110- U8 (Telemonitoring Equipment)

Effective 1/1/24, at least one of the following diagnoses must be submitted on the RPM claim:

- Hypertension Code
- Diabetes-DM-1 Code
- Diabetes-DM-2 Code
- Gestational Diabetes Code
- Congestive Heart Failure Code
- Pediatric Asthma Code

Billing Units: 5 minutes equals one unit

111.4.3 *Cost Sharing (Copayment)*

Copayment does not apply to services provided by RPM providers.

111.4.4 *Time Limit for Filing Claims*

Medicaid requires all claims for RPM services to be filed within one year of the date of service. Refer to Chapter 5, Filing Limits and Approved Exceptions, for more information regarding timely filing limits and exceptions.

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111.5 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find it
Becoming a Medicaid Provider	Chapter 2
Verifying Recipient Eligibility	Chapter 3
CMS 1500 Claim Filing Instructions	Chapter 5
Alabama Coordinated Health Network (ACHN)	Chapter 40
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N

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112

112 Telemedicine Services

This general information is related to the telehealth medical services rendered by Alabama Medicaid (Medicaid) providers. Providers are expected to comply with Alabama's Telehealth Medical Services law (Code of Alabama, Sections 34-24-701 through 34-24-707) at all times.

112.1 Enrollment

Alabama Medicaid's fiscal agent enrolls providers and issues provider contracts to applicants who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code*, and the *Alabama Medicaid Provider Manual*.

Federal requirements mandate providers re-validate periodically with the Alabama Medicaid program. Providers will be notified when they are scheduled to re-validate. Failure to re-validate and provide appropriate documentation to complete enrollment will result in an end-date being placed on the provider file. Once a provider file has been closed for failure to timely re-validate, providers will have to submit a new application for enrollment.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

National Provider Identifier, Type, and Specialty

A provider who contracts with Alabama Medicaid as an enrolled provider is added to the Alabama Medicaid system with the National Provider Identifiers provided at the time application is made. Appropriate provider specialty codes are assigned to enable the provider to submit requests and receive reimbursements.

NOTE:
The 10-digit NPI is required when filing a claim.

Providers must submit the Telemedicine Service Agreement/Certification to Medicaid's fiscal agent. The form is located on the Medicaid website at: www.medicaid.alabama.gov. Once the form is received, providers will be enrolled with Medicaid with a specialty type of 931 (Telemedicine Service). Providers must have the specialty type of 931 to bill for telemedicine services.

Provider Types Eligible for Reimbursement for Telemedicine Services

- Physicians
- Certified Registered Nurse Practitioners (CRNPs)

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- Physician Assistants
- Rehabilitative Option Providers
- Psychologists
- Licensed Professional Counselors
- Associate Licensed Counselors
- Licensed Marriage and Family Therapist and Associates
- Licensed Master Social Workers
- Licensed Independent Clinical Social Workers
- Licensed Psychological Technicians
- Speech Therapists
- Optometrists
- Applied Behavior Analysts
- Early Intervention
- Children's Rehabilitation Service
- Pharmacists/Pharmacies
- Targeted Case Management

Provider Types Not Eligible for Reimbursement for Telemedicine Services

- Physical Therapists
- Occupational Therapists
- DME suppliers
- Ambulance providers
- Chiropractors
- Home Infusion
- Laboratory

General Enrollment Policy for Telemedicine Services Providers

Refer to the respective Alabama Medicaid Provider Billing Manual chapter that describes the service rendered by providers listed above for general enrollment information.

112.2 Benefits and Limitations

This section describes telemedicine provider requirements. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations. Refer to Chapter 7, Understanding Your Rights and Responsibilities as a Provider, for general criteria on Medical Necessity/ Medically Necessary Care.

Definitions

As found in Alabama law the following definitions apply to Medicaid's telemedicine policy:

Telehealth medical services means "digital health, telehealth, telemedicine, and the applicable technologies and devices used in the delivery of telehealth.

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The term does not include incidental communications between a patient and a physician.

- Digital Health is defined as “the delivery of health care services, patient education communications, or public health information via software applications, consumer devices, or other digital media.”
- Telehealth is defined as “the use of electronic and telecommunications technologies, including devices used for digital health, asynchronous and synchronous communications, or other methods, to support a range of medical care and public health services.”
- Telemedicine is defined as “a form of telehealth referring to the provision of medical services by a physician at a distant site to a patient at an originating site via asynchronous or synchronous communications, or other devices that may adequately facilitate and support the appropriate delivery of care. The term includes digital health but does not include incidental communications between a patient and a physician.”

The term irregular or infrequent services refers to “telehealth medical services” occurring less than 10 days in a calendar year or involving fewer than 10 patients in a calendar year.

Synchronous is defined as “the real-time exchange of medical information or provision of care between a patient and a physician via audio/visual technologies, audio-only technologies, or other means.”

Telemedicine Provider Requirements

Providers must identify themselves to the recipient with their credentials and name at the time of service.

Providers must obtain prior written or verbal consent from the recipient before services are rendered.

Telemedicine services may only be provided as a result of a patient’s request, part of an expected follow up, or a referral from the patient’s licensed physician with whom the patient has an established patient-physician relationship.

Services rendered via telecommunication system must be provided by a provider who is licensed, registered, or otherwise authorized to engage in his or her healthcare profession in the state where the patient is located. Per Alabama law, the provision of telemedicine medical services is deemed to occur at the patient’s originating site within this state.

Services must be within the provider’s scope of license.

Services must be provided to a recipient that is an established patient of the provider or practice or due to a referral made by a patient’s licensed physician with whom the patient has an established physician-patient relationship, in the usual course of treatment of the patient’s existing health condition.

Telemedicine services provided to minors under the age of medical consent must have a parent or legal guardian attend the telemedicine visit.

Only the provider rendering the services via telemedicine may submit for reimbursement for services.

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Providers must indicate an in-state or qualifying bordering state site of practice address from which telemedicine services will be provided.

NOTE:

This policy does not expand or grant any authority outside that authority granted to the provider by their respective licensure board or by federal or state law.

Delivery Requirements of Telemedicine Services

Services must be administered via an interactive audio or audio and video telecommunications system which permits two-way communication between the distant site provider and the site where the recipient is located (this does not include electronic mail message or facsimile transmission between the provider and recipient).

Telemedicine health care providers shall ensure that the telecommunication technology and equipment used is sufficient to allow the health care provider to appropriately evaluate, diagnose, and/or treat the recipient for services billed to Medicaid and is HIPAA compliant.

Transmissions must utilize an acceptable method of encryption adequate to protect the confidentiality and integrity of the transmission information. Transmissions must employ acceptable authentication and identification procedures by both the sender and the receiver.

The provider shall implement confidentiality protocols that include, but are not limited to:

a. specifying the individuals who have access to electronic records;

b. usage of unique passwords or identifiers for each employee or other person with access to the client records;

c. ensuring a system to prevent unauthorized access, particularly via the internet; and

d. ensuring a system to routinely track and permanently record access to such electronic medical information.

These protocols and guidelines must be available for inspection at the telemedicine site and to Medicaid upon request.

NOTE:

A covered telemedicine service will count towards each recipient's benefit limit of 14 annual physician office visits.

Documentation of Services Delivered via Telemedicine

Providers shall document in the medical record detailed information of the telemedicine visits including, but not limited to:

- Identification of the patient.

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- Identification of parent or legal guardian attending the telemedicine visit if recipient is under the age of medical consent.
- Physical location of the patient, including the city and state.
- The medical record documentation must accurately reflect the services rendered and the level of medical decision making to substantiate the procedure code billed.
- The same “in” and “out” documentation is required for telemedicine as is required for current services with incremental timeframes provided in person.
- Identification of the provider including credentials.
- Patient’s consent for the use of telemedicine delivery of health care services. This consent must be documented in the recipient’s medical record.
- Condition for which the care is being provided.
- Medical necessity and appropriateness of services billed.
- Follow up care needed.
- Other relevant details of the visit, to include BMI recording, when applicable.

Origination Sites

The following are required for the origination site where the patient is located:

- The site provider shall ensure that the telecommunication technology and equipment used at the origination site is HIPAA compliant and is sufficient to allow the appropriate evaluation, diagnosis, and/or treatment of the patient.
- The site provider shall implement protocols that ensure the same confidentiality of the telemedicine visit as for in-person visits.
- Regardless of the location of the recipient, it is the provider’s responsibility to ensure the telemedicine visit meets all required HIPAA rules and regulations regarding telemedicine visits.
- The following sites are recognized by Medicaid as origination sites:
  - Physician and practitioner offices
  - Hospitals
  - Rural Health Clinics (RHCs)
  - Federally Qualified Health Centers (FQHCs)
  - Hospital-based or CAH-based Renal Dialysis Centers (including satellites)
  - Skilled Nursing Facilities (SNFs)
  - Community Mental Health Centers (CMHCs)
  - Renal Dialysis Facilities
  - Mobile Stroke Units
  - Alabama Department of Public Health

Telemedicine services can be rendered to a recipient in their home. However, a recipient’s home should not be considered an origination site entitled to receive an origination site fee.

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NOTE:

If a Medicaid-enrolled provider performs another medically necessary service(s), the provider may bill for the covered service(s) in addition to providing his/her facility as an origination site and be eligible for reimbursement for the origination site facility fee and the other medically necessary service(s).

Prescribing of Medications and Controlled Substances via Telemedicine

In accordance with Alabama's Telemedicine Law, an enrolled provider may prescribe a legend drug, medical supplies, or a controlled substance via telemedicine if the prescriber is authorized to do so under state and federal law. However, a prescription for a controlled substance may only be issued via telemedicine if:

- The telemedicine visit includes synchronous audio or audio-visual communication using HIPAA compliant equipment with the prescriber;
- The prescriber has had at least one in-person encounter with the patient within the preceding 12 months; and
- The prescriber has established a legitimate medical purpose for issuing the prescription within the preceding 12 months.

BMI Requirements

The BMI will be required for office visits including the telemedicine visits. The BMI is required at least once per calendar year on all claims with procedure codes 99201-99205, 99211- 99215, and 99241-99245 and EPSDT procedure codes 99382-99385 and 99392-99395. Providers should use subjective data to calculate the BMI which can include providers asking the recipient for his or her height and weight during the telemedicine visit. The BMI should be calculated, based on the information provided by the recipient, and appended to the claim for reimbursement. The BMI should also be documented in the recipient's medical record.

Remote Patient Monitoring

For information related to Remote Patient Monitoring, please refer to Chapter 111 - Remote Patient Monitoring (RPM) of the Provider Billing Manual.

112.3 Prior Authorization and Referral Requirements

Prior authorization is not required for services to be delivered via telemedicine, though prior authorization may be required for the individual procedure codes billed. Refer to the Provider Billing Manual chapter that describes the service provided for prior authorization requirements.

Refer to Appendix A and the respective Alabama Medicaid Provider Billing Manual chapter that describes the service provided for information about Early and Periodic Screening, Diagnostic, and Testing (EPSDT) referrals.

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112.4 Cost Sharing (Copayment)

The copayment amount for office visit* including crossovers is:

$3.90 for procedure codes reimbursed $50.01 and greater
$2.60 for procedure codes reimbursed between $25.01 and $50.00
$1.30 for procedure codes reimbursed between $10.01 and $25.00

* The following CPT codes are considered office visits and the copayment is based on Medicaid's allowed amount (fee schedule) for each procedure:

99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

Copayment does not apply to services provided for pregnant women, nursing home residents, recipients less than 18 years of age, emergencies, and family planning. Native American Indians that present an "active user letter" issued by Indian Health Services (IHS) will be exempt from the Medicaid required copayment.

The provider may not deny services to any eligible Medicaid recipient because of the recipient's inability to pay the cost-sharing (copayment) amount imposed.

112.5 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

Providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

Refer to the respective Alabama Medicaid Provider Billing Manual chapter that describes the service provided for general information on completing the appropriate claim form.

This section describes telemedicine services information. Providers should refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

112.5.1 Time Limit for Filing Claims

Medicaid requires all claims for providers to be filed within one year of the date of service. Refer to Chapter 5 for more information regarding timely filing limits and exceptions.

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112.5.2 Diagnosis Codes

The *International Classification of Diseases - 10th Revision - Clinical Modification* (ICD-10-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, AMA Plaza 330 North Wabash Ave, Suite 39300 Chicago, IL 60611-5885 or 1-800-621-8335.

Refer to the respective Alabama Medicaid Provider Billing Manual chapter that describes the service provided by providers listed in Section 112.1 for general information for billing appropriate diagnosis codes with procedure codes and modifiers listed in Section 112.5.3.

112.5.3 Procedure Codes and Modifiers

Procedure Codes

Procedure codes listed below are reimbursable services when delivered via telemedicine by a provider type listed in Section 112.1. The procedure codes (and applicable modifiers) are listed below by provider type or services. For further detailed information, refer to the below referenced chapters of the Provider Billing Manual.

Eye Care – Chapter 15

- Office visit codes for established patients: CPT 99211-99215

CRNPs/PAs Services– Chapter 21

- Office or other outpatient visits for recipients ages 21 and older: CPT 99202-99205, 99211-99215
- **Office or other outpatient visits for recipients ages 0-20 billed as an EPSDT referred service: CPT 99211-99215
- **EPSDT interperiodic screenings for recipients ages 0-20: CPT 99211-EP-99215-EP
- Initial hospital inpatient or observation care: CPT 99221-99223
- Subsequent hospital inpatient or observation care: CPT 99231-99233
- Hospital inpatient or observation care: CPT 99234-99236
- Hospital inpatient or observation discharge day management: CPT 99238-99239
- Office or other outpatient consultation: CPT 99242-99245
- Inpatient or observation consultation: CPT 99252-99255
- Psychiatric diagnostic testing: CPT 90791
- Psychiatric diagnostic testing with medical services: CPT 90792

***Refer to Appendix A – Well Child Visit (EPSDT) for information on billing. Claims not billed for telemedicine services in compliance with policy may be subject to recoupment.*

Physician Services – Chapter 28

- Office or other outpatient visits for recipients ages 21 and older: CPT 99202-99205, 99211-99215
- **Office or other outpatient visits for recipients ages 0-20 billed as an EPSDT referred service: CPT 99211-99215
- **EPSDT interperiodic screenings for recipients ages 0-20: CPT 99211-EP – 99215-EP
- Initial hospital inpatient or observation care: CPT 99221-99223

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- Subsequent hospital inpatient or observation care: CPT 99231-99233
- Hospital inpatient or observation care: CPT 99234-99236
- Hospital inpatient or observation discharge day management: CPT 99238-99239
- Office or other outpatient consultation: CPT 99242-99245
- Inpatient or observation consultation: CPT 99252-99255
- Psychiatric diagnostic testing: CPT 90791
- Psychiatric diagnostic testing with medical services: CPT 90792

***Refer to Appendix A – Well Child Visit (EPSDT) for information on billing. Claims not billed for telemedicine services in compliance with policy may be subject to recoupment.*

Behavioral Health – Chapter 34

- Psychotherapy:
  - *CPT 90832, 90834, 90837, 90846, 90847 and
  - *HCPCS H2011 [psychologist only]

*** denotes service must be done with both audio and visual (GT modifier)**

Applied Behavioral Analysis Therapy – Chapter 37

- Behavior Identification Assessment: CPT 97151
- Observational F/U assessment: CPT 97152
- Exposure Behavioral F/U Assessment: HCPCS 0362T
- Adaptive Behavior Treatment: CPT 97153
- Group Adaptive Behavior Treatment: CPT 97153
- Social Skills Group: CPT 97154
- Exposure Adaptive Behavior Treatment: HCPCS 0373T
- Adaptive Behavior Modification: CPT 97155
- Family Adaptive Behavior Treatment Guidance: CPT 97156
- Multiple Family, Group Treatment Guidance: CPT 97157

Speech Therapy – Chapter 37

- Treatment of speech: CPT 92507, 92508
- Evaluation of speech sound production: CPT 92523

Children's Rehabilitation Service – Chapter 100

- Office visits: CPT 99202-HT, 99203-HT, 99204-HT, 99205-HT, 99212-HT, 99213-HT, 99214-HT, 99215-HT

Rehabilitative Option Services– Chapter 105

- *Psychiatric evaluation: CPT 90791, 96130, 96131
- *Psychotherapy: CPT 90832, 90834, 90837, 90846, 90847, 90853, 90849
- *Psychological testing: CPT 96136, 96137, 96138, 96139, 96146
- *Assessments: HCPCS H0002, H0004, H0031-HF
- *Medication Monitoring: HCPCS H0034
- *Peer support services: HCPCS H0038 (with appropriate modifiers)
- *Crisis intervention: CPT H2011
- *Treatment plan review: HCPCS H0032
- *Mental health care coordination: HCPCS H0046
- *Assertive Community Treatment (ACT) H0040-HE (Psychiatrist only)
- *Behavioral Health Placement Assessment H0002-HE
- *Psychoeducational Services H2027- HE

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- *Screening H0049-HF
- *Brief Intervention H0050-HF
- *Nursing Assessment and Care T1001
- *Nursing Assessment and Care T1002
- *Nursing Assessment and Care T1003
- *Therapeutic Mentoring H2019 – HE:HA

***denotes service must be done with both audio and visual (GT modifier)**

Targeted Case Management – Chapter 106

Deleted: ~~HCPCS~~
Deleted: ~~HCPCS~~
Added: Group 3
Deleted: ~~HCPCS~~
Deleted: ~~HCPCS~~
Deleted: ~~HCPCS~~
Deleted: ~~HCPCS~~
Added: Group 10
Added: Group 10
Deleted: ~~and~~

- *Group 1: G9008-U1
- *Group 3: G9002-U3,
- *Group 3: G9002-UA
- *Group 4: T2023-U4
- *Group 6: G9012-U6
- *Group 9: G9008-U9
- *Group 10: G9003-UA TG,
- *Group 10: G9003-UA
- *Group 10: G9008-U1 TG

***denotes service must be done with both audio and visual (GT modifier)**

Early Intervention – Chapter 108

- Intake Evaluation: HCPCS T1023
- Audiology: CPT 92550-TL, 92552-TL, 92553-TL, 92555-TL, 92556-TL, 92557-TL, 92567-TL, 92568-TL, 92579-TL, 92582-TL, 92583-TL, 92587-TL
- Family Support: HCPCS H2027-TL
- Psychological Testing: CPT 96111-TL
- Speech-Language Pathology: CPT 92507-TL, 92508-TL, 97532-TL
- Vision Services: CPT 99173-TL
- Treatment Plan Review: HCPCS H0032-TL

Rehabilitative Services (ASD)- Chapter 110

- *Behavior Support H2019
- *In-Home Therapy T1027
- *Mental Health Care Coordination H0046
- *Peer Support Youth H0038- HA
- *Peer Support Family H0038-HC
- *Psychoeducational Services H2027
- Therapeutic Mentoring H2014

***denotes service must be done with both audio and visual (GT modifier)**

Modifiers

Providers meeting the telemedicine provider requirements listed above must append one of the following modifiers indicating the mode of telemedicine service delivery:

- GT for covered telemedicine services delivered via audio and visual telecommunications.
- FQ for covered telemedicine services delivered via audio only telecommunications.

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Additional modifiers may be required. Refer to the chapter of the Provider Billing Manual that describes services provided for further information.

Reimbursement for services provided via telemedicine, audio only and audio and video telecommunications, will be paid at parity to those services provided face-to-face. Medicaid will continue to monitor and reevaluate, if deemed necessary.

Billing the Telemedicine Origination Site Facility Fee

Effective April 1, 2020, Medicaid pays an origination site facility fee of $20.00. The origination fee will be limited to one per date of service per recipient and may be billed by all of the providers listed above under Origination Sites (Section 112.2).

No origination site facility fee will be paid for an origination site not listed above. To receive the origination site facility fee, the following must be included on a CMS-1500 or UB-04 claim:

	Procedure Code
Providers	Q3014
Federally Qualified Health Centers and Rural Health Clinics	Q3014 (independent of the encounter rate)

NOTE:

If a Medicaid-enrolled provider performs another medically necessary service(s), the provider may bill for the covered service(s) in addition to providing his/her facility as an origination site and be eligible for reimbursement for the origination site facility fee and the other medically necessary service(s).

A recipient's home should not be considered an origination site entitled to receive an origination site fee.

Services not Eligible for Reimbursement for Telemedicine Services

Common examples of services via telemedicine not considered for reimbursement (not exhaustive):

- Chart reviews
- Electronic mail messages (between providers and recipients)
- Facsimile transmissions (between providers and recipients)
- Consultation between two providers
- Internet based communications that are not HIPAA-compliant or secure
- Services not directly provided by an enrolled provider or by office staff
- Services not normally charged for during an office visit

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- Services not specifically listed in Provider Billing Manual chapters
- Communication that is not secure or HIPAA-compliant (e.g., Skype, FaceTime)

Exceptions may be made to the lists for providers and services not reimbursable under this policy in the event of a public health emergency, however, separate guidance would be issued in those instances.

NOTE:

If a Medicaid-enrolled provider performs another medically necessary service(s), the provider may bill for the covered service(s) in addition to providing his/her facility as an origination site and be eligible for reimbursement for the origination site facility fee and the other medically necessary service(s).

112.5.4 Place of Service Codes

Refer to the respective Alabama Medicaid Provider Billing Manual chapter that describes the service provided for general information on completing the appropriate claim form.

112.5.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to the following circumstances:

- Claims with Third Party Denials

NOTE:

When an attachment is required, a hard copy CMS-1500 claim form must be submitted.

Refer to Chapter 5 Required Attachments, for more information on attachments.

112.6 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	Chapter 5
Medical Necessity/Medically Necessary Care	Chapter 7
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N

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A Well Child Visit (EPSDT)

The purpose of EPSDT services is:

- To actively seek out all eligible families and educate them on the benefits of preventive health care
- To help recipients effectively use health resources and encourage them to participate in the screening program at regular intervals
- To provide for the detection of any physical and mental problems in children and youth as early as possible through comprehensive medical screenings in accordance with program standards
- To provide for appropriate and timely services to correct or ameliorate any acute or chronic conditions

This appendix offers information about the EPSDT program. It consists of the following sections:

Section	***Contents***
Understanding EPSDT	Provides an overview of EPSDT, including descriptions of screening types and services offered under EPSDT
Performing Screenings	Provides information on becoming an EPSDT screening provider, verifying recipient eligibility, critical components of screenings, and how to submit claims for EPSDT screenings
Providing and Obtaining Referrals	Describes the process for providing referrals to specialists and obtaining referrals from screening providers.
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.

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A.1 Understanding EPSDT

The purpose of the EPSDT program is to find children with actual or potential health problems and to screen, diagnose, and treat the problems before they become permanent, lifelong disabilities. The program also offers preventive health services to Medicaid-eligible children under 21 years of age.

The EPSDT program was expanded in the Omnibus Budget Reconciliation Act of 1989 to allow additional services. The acronym EPSDT stands for:

Early	A Medicaid-eligible child should begin to receive high quality preventive health care as early as possible in life.
Periodic	Preventive health care occurring at regular intervals according to an established schedule that meets reasonable standards of medical, vision, hearing, and dental practice established by recognized professional organization.
Screening	A comprehensive, unclothed head-to-toe physical examination to identify those who may need further diagnosis, evaluation, and/or treatment of their physical and mental problems.
Diagnosis	The determination of the nature or cause of physical or mental disease, conditions, or abnormalities identified during a screening.
Treatment	Any type of health care or other measures provided to correct or ameliorate defects, physical and mental illnesses, or chronic conditions identified during a screening.

Periodicity Schedule

Periodic screenings must be performed in accordance with the schedule listed below. This schedule is based upon the recommendations of the American Academy of Pediatrics.

- 1 month
- 2 months
- 4 months
- 6 months
- 9 months
- 12 months
- 15 months
- 18 months
- 24 months
- Then annually (per calendar year) through 20 years of age beginning with the third birthday

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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, Gainwell Provider Electronic Solutions software, or the Provider Assistance Center at Gainwell. Please refer to Chapter 3, Verifying Recipient Eligibility, for more information.

If a periodic screening has not been performed on time according to the periodicity schedule (for instance, if the 2 months' periodic screening was missed), a screening may be performed at an “in between” age (for example, at 3 months) and billed as a periodic screening. In other words, the child should be brought up to date on his/her screening according to his/her age. Re-screenings should occur within 2 weeks (before or after) of the established periodicity schedule. This policy applies to recipients 0-24 months of age.

EPSDT screenings fall under six broad categories:

Type of Screening	***Description***
Initial Screening	Initial screenings indicate the first time an EPSDT screening is performed on a recipient by an EPSDT screening provider.
Periodic Screening	Periodic screenings are well child visits performed based on a periodicity schedule. The ages to be screened are 1 month, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 24 months, and annually beginning on or after the child’s third birthday.
Interperiodic Screening	Interperiodic screenings are considered problem-focused and abnormal. These are performed when medically necessary for undiagnosed conditions outside the established periodicity schedule and can occur at any age.
Vision Screening	Vision screenings must be performed on children from birth through age two by observation (subjective) and history. Objective testing begins at age three and should be documented in objective measurements.
Hearing Screening	Hearing screenings must be performed on children from birth through age four by observation (subjective) and history. Objective testing begins at age five and should be recorded in decibels.
Dental Screening	Dental screenings must be performed on children from birth through age two by observation (subjective) and history. Beginning with age one, recipients must be either under the care of a dentist or referred to a dentist for dental care.
Emotional and behavioral Screening	Emotional Assessment will cover procedure code 96127 for children age 3 months - 20 years. Assessment must be ordered and signed by a physician or Non- Physician Practitioner (i.e., Psychologist, Physician Assistant, or Certified Registered Nurse Practitioner).

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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, ACHN, and Medicaid family planning providers who receive training in the use of the PT+3 method of education. For more information regarding PT+3, please fax your request to (334) 353-5203, attention "Outreach & Education." Please include your name and telephone number.

A.3 Performing Screenings

This section describes becoming an EPSDT screening provider, verifying recipient eligibility, scheduling screenings, critical components of screenings, and submitting claims for EPSDT screenings.

A.3.1 Becoming an EPSDT Screening Provider

Participation as an EPSDT screening provider is voluntary. To become an EPSDT screening provider, a provider must be an approved Alabama Medicaid provider and must have a 10-digit NPI. New providers should refer to Chapter 2, Becoming a Medicaid Provider, for instructions on receiving an application.

Federal requirements mandate providers re-validate periodically with the Alabama Medicaid program. Providers will be notified when they are scheduled to re-validate. Failure to re-validate and provide appropriate documentation to complete enrollment will result in an end-date being placed on the provider file. Once a provider file has been closed for failure to timely re-validate, providers will have to submit a new application for enrollment.

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Current Medicaid providers who wish to become an EPSDT screening provider may download the information and forms from the Alabama Medicaid website (https://medicaid.alabama.gov/) or contact the Gainwell Provider Enrollment Unit at the following address:

Gainwell Provider Enrollment
P.O. Box 241685
Montgomery, Alabama 36124-1685
1 (888) 223-3630

Provider Types Eligible for Participation

Only certain Alabama Medicaid provider types may become approved EPSDT screening providers. In some cases, these providers are restricted to where they can perform screenings:

This Provider Type	***May Perform Screenings at the Following Locations:***
Physicians	Anywhere a physician is authorized to practice
Nurse practitioners	At a physician's office, Rural Health Clinic, Federally Qualified Health Care Clinic (FQHC), health department, or hospital
Registered Nurses	At a rural health clinic, Federally Qualified Health Care Clinic (FQHC), health department, or hospital **NOTE:** Two-year degree RNs who wish to perform EPSDT screenings must first complete a Medicaid-approved pediatric health assessment course (PAC) or show proof of completion of a similar program of study. BSN's are exempt from taking a PAC.
Physician Assistants	At a physician's office, rural health clinic, Federally Qualified Health Care Clinic (FQHC), health department, or hospital

Providers are not limited to those who are qualified to provide the full range of medical, vision, hearing, and dental screening services. Although a qualified provider may be enrolled to furnish one or more types of screening services, the Alabama Medicaid Agency encourages qualified providers to provide the full range of medical, vision, hearing, and dental screening services to avoid fragmentation and duplication of services.

NOTE:

Medical screenings, including the physical, must be performed by a physician, certified nurse practitioner, registered nurse, or physician's assistant, who is approved to perform well child visits. Other trained personnel may perform some screening components (for instance, measurements or finger sticks).

Refer to Chapter 112, Telemedicine Service, for general benefit information and limitations.

Potential EPSDT off-site providers must submit specific documents (see Section A.5) and be approved to participate as an off-site provider.

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A.3.2 Verifying Recipient Eligibility

Reimbursement will be made only for eligible Medicaid recipients. Eligibility and benefit limits should be verified **prior to rendering** services to **ANY** Medicaid recipient.

NOTE:

Every effort should be made to assure that medical, dental, vision, and hearing screenings, including immunizations, are accomplished in one visit, and that fragmentation or duplication of screening services is prevented. Section A.7, Vaccines for Children, describes the immunization schedule.

To be eligible for Medicaid, recipients must meet certain criteria. It is crucial for a provider to check the eligibility prior to performing services. Eligibility verification will help ensure that the provider claim gets paid. Some examples of what a provider will be informed of when checking eligibility include:

- The type of eligibility which indicates services the recipient may obtain
- The attributed provider
- The number of screenings that have been performed
- The 13th digit of the recipient Medicaid identification number

For details about eligibility please refer to Chapter 3: Verifying Recipient Eligibility.

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. SSI (Category 4) eligible recipients are informed of EPSDT services. The Medicaid-eligible child is permitted to see any Alabama Medicaid provider for EPSDT services without a referral from PCP.

Once the child has had an EPSDT screening, all subsequent visits to other providers for further diagnosis or treatment must have a prior approved written referral (Form 362) from the EPSDT screening provider.

For more information regarding the ACHN, refer to Chapter 40 - ACHN of this manual or call the Provider Assistance Center at (800) 688-7989.

The Alabama Medicaid Agency's goal is to provide effective outreach services for Medicaid-eligible recipients. EPSDT outreach efforts are aimed at two groups: (a) new Medicaid recipients and (b) all Medicaid-eligible recipients under 21 years of age who have not had a well child screening in the last 12 months. These recipients are notified twice annually. The recipient is informed about EPSDT services through an outreach letter and is encouraged to make an appointment for an EPSDT screening.

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A.3.4 EPSDT Care Coordination

The goal for ACHN Care Coordination Services is to provide children with opportunities to maximize their health and development by ensuring the availability and accessibility of comprehensive and continuous preventive health services throughout childhood. The ACHN Care Coordination services are available to any provider, at no cost, who wishes to benefit from effective intervention. These Medicaid eligible recipients will then be targeted for outreach.

The scope of services are also designed to support and assist your office personnel with identifying, contacting, coordinating, and providing follow up office visits for children who are behind on their EPSDT screenings. These services include but are not limited to: immunizations, vision/hearing screenings, dental screenings, identifying recipients who have high utilization of emergency room visits; follow up regarding referrals, missed appointments, and coordination for teen pregnancy prevention services. In addition, Care Coordinators are available to assist with transportation services using Alabama Medicaid's Non-Emergency Transportation (NET) program. ACHN Care Coordinators may receive referrals from physicians and dentists regarding medically-at-risk clients who need assistance with keeping appointments and obtaining follow-up care. Lastly, ACHN Care Coordinators will encourage and assist in recruiting private physicians to improve services to this population.

Participation of qualified EPSDT Care Coordination services is available through the ACHNs whose primary role is that of care coordinator. Active physician involvement for treatment is vital. ACHN Care Coordination services are available by contacting your regional ACHN. Please visit our website at www.medicaid.alabama.gov and select "ACHN": ACHN Home: ACHN Providers: "ACHN Interactive Map" or ACHN Contact Information for Providers. A list of ACHN Care Coordinators by county and telephone numbers is available to support your office personnel.

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A.3.5 Scheduling Screenings

The Alabama Medicaid Agency requires that persons requesting screening services receive the services within 120-180 days from the date the request was made. These persons should be given priority by the screening agency when scheduling appointments.

EPSDT selected providers and Primary Care Physician (PCP) receive a periodic re-screen list each month. The provider should utilize the periodic re-screen list to notify the EPSDT-eligible recipient when the medical screening is due. An appointment should be made for the next screening on the periodicity schedule. These functions are an integral part of the full screening provider's responsibility and are essential for care coordination. Providers have a total of 120 days from due date or award date (listed on printout) to accomplish screening, necessary referral, and treatment for the recipients listed on the printout.

EPSDT-eligible Medicaid beneficiaries who request well child visits 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. The ACHN is responsible for overall care coordination for medical, vision, hearing, and dental screenings for recipients who participate in the ACHN program.

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. An additional interperiodic screening may be performed if requested by the parent or if medically necessary.

Please refer to Section A.5, Care Coordination, for more information on screening provider responsibilities.

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A.3.6 Critical Components of Screenings

This section describes critical components of periodic, interperiodic, and vision/hearing/dental screenings. It also describes recommended health education counseling topics by age group.

Periodic Screenings

Component	*Description*
Unclothed physical exam	This is a comprehensive head-to-toe assessment that must be completed at each screening visit and include at least the following: • Temperature, and height/weight ratio • Head circumference through age two • Blood pressure and pulse at age three and above • Measure body-mass index when clinically indicated Body-mass index (BMI) – BMI should be performed at each visit if clinically indicated. BMI-for-age charts are recommended to assess weight in relation to stature for children ages 2 to 20 years. The weight-for-stature charts are available as an alternative to accommodate children ages 2-5 years who are not evaluated beyond the preschool years. However, all health care providers should consider using the BMI-for-age charts to be consistent with current recommendations. The charts are available on the American Academy of Pediatrics website at http://www.aap.org.
Comprehensive family/medical history	This information must be obtained at the initial screening visit from the parent(s), guardian, or responsible adult who is familiar with the child's history. The history must include an assessment of both physical and mental health development and the history must be updated at each subsequent visit.
Immunization status	Immunizations and applicable records must be updated according to the current immunization schedule of the Advisory committee on Immunization Practices (ACIP). Dates and providers must be recorded in the medical record indicating when and who gave the vaccines, if not given by the screening provider. The state law has been changed so that private and public healthcare providers may share immunization data. Medicaid recipients shall be deemed to have given their consent to the release by the state Medicaid Agency of information to the State Board of Health or any other health care provider, by virtue immunization data should be recorded in the medical record.

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Component	*Description*
TB skin test	Children who should be considered for tuberculin skin testing (TST): 1. Children whose parents (with unknown TST status) immigrated from regions of the world with high prevalence of tuberculosis; continued potential exposure by travel to endemic areas and/or household contact with persons from the endemic areas (with unknown TST status) should be tested. 2. Children without specific risk factors who reside in high-prevalence areas should be tested. In general, a high-risk neighborhood or community does not mean an entire city is at high risk. Rates in any area of the city may vary by neighborhood or even from block to block. Physicians should be aware of these patterns in determining the likelihood of exposure; public health officials or local tuberculosis experts should help physicians identify areas with appreciable tuberculosis rates. 3. Children at increased risk for progression of infection to disease should be tested. Those with medical conditions such as diabetes mellitus, chronic renal failure, malnutrition or congenital or acquired immunodeficiency deserve special consideration. Without recent exposure, these children are not at increased risk of acquiring tuberculosis infection. Underlying immune deficiencies associated with these conditions theoretically enhance the possibility for progression to severe disease. Initial histories of potential exposure to tuberculosis should be included for all of these patients. If these histories or local epidemiologic factors suggest a possibility of exposure, immediate and periodic TST should be considered. An initial TST should be performed before initiation of immunosuppressive therapy for any child with an underlying condition that necessitates immunosuppressive therapy. Bacille Calmette-Guérin (BCG) immunization is not a contraindication to TST. HIV indicates human immunodeficiency virus.
Definitions of positive TST	Definitions of positive tuberculin skin testing (TST) per CDC.gov: 1. TST should be read between 48 - 72 hours after administration by a health care worker trained to read TST results. 2. The diagnosis of TB disease in children is often made without laboratory confirmation and instead based on combination of the following factors: • Clinical signs and symptoms typically associated with TB disease, • Positive tuberculin skin test (TST) or positive TB blood test (IGRA), • Chest x-ray that has patterns typically associated with TB disease, and • History of contact with a person with infectious TB disease.

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Component	*Description*
	3. Classification of the TST Reaction **A. Induration >5mm** • People living with HIV. • A recent contact of a person with infectious TB disease. • People with chest x-ray findings suggestive of previous TB disease. • People with organ transplants. • Other immunosuppressed people (e.g., patients on prolonged therapy with corticosteroids equivalent to/greater than 15 mg per day of prednisone or those taking TNF-a antagonists) **B. Induration >10mm** • People born in countries where TB disease is common, including Mexico, the Philippines, Vietnam, India, China, Haiti, and Guatemala, or other countries with high rates of TB. • People with certain medical conditions that place them at high risk for TB (e.g., silicosis, diabetes mellitus, severe kidney disease, certain types of cancer, and certain intestinal conditions) • Children younger than 5 years of age • Infants, children, and adolescents exposed to adults in high-risk categories **C. Induration >15mm** • People with no known risk factors for TB
Developmental surveillance and assessment	A comprehensive developmental history is required, if appropriate, to determine the existence of motor, speech, language, and physical problems or to detect the presence of any developmental lags. An age-appropriate developmental assessment is required at each screening. Information must be acquired on the child's usual functioning as reported by the child's parent, teacher, health care professional, or other knowledgeable individual. **Developmental assessments must be performed by a RN, BSN; CRNP, PA, or M.D.**
Nutritional status screening	Nutritional status must be assessed at each screening visit. Screenings are based on dietary history, physical observation, height, weight, head circumference (ages two and under), hemoglobin/hematocrit, and any other laboratory determinations carried out in the screening process. A plotted height/weight graph chart is acceptable when performed in conjunction with a hemoglobin or hematocrit if the recipient falls between the 10th and 95th percentile.
Health education including anticipatory guidance	Health education and counseling for parent(s) or guardian and the youth (if age appropriate) are required at each screening visit. Health education is designed to assist the parent in understanding what to expect in terms of development. Health education also provides information about the benefits of healthy lifestyles and practices, as well as accident and disease prevention. Providers may use the PT+3 teaching method for anticipatory guidance counseling. PT+3 should be documented in the medical record (i.e., progress notes) listing the three points emphasized.
Objective Developmental Screenings	SEE BELOW

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Objective Developmental Screenings

EPSDT providers are allowed to bill for an objective developmental screening in addition to an EPSDT screening at the 9 month, 18 month, 24 month and 48 month well-child visit. EPSDT providers also have the option of providing the developmental screening anytime that surveillance (medical history of developmental risk factors, parental/caregiver concern) identifies a need. Providers are encouraged to use standardized screening tools that have a moderate to high sensitivity, specificity, and validity level and are culturally sensitive. The following code, which is limited to five (5) units per date of service (five different screening tools used), may be used to bill for this screening:

> 96110 - Developmental testing; limited (e.g., Developmental Screening Test II, Early Language Milestone Screen), with interpretation scoring and reporting documentation per standardized instrument (provider must document description of score).

In order to bill this code, providers must use a standardized screening tool. Examples of screening tools allowed for this code include, but are not limited to:

- Ages and Stages Questionnaire (ASQ)
- Denver DST/Denver II
- Battelle Developmental Screener
- Bayley Infant Neurodevelopment Screener (BINS)
- Parents Evaluation of Development (PEDS)
- Early Language Accomplishment Profile (ELAP)
- Brigance Screens II
- Pediatric Symptom Checklist (PSC)

The developmental screening tool must be ordered by the provider or on behalf of the provider based on developmental screening written protocol/standing orders and scored (Provider must document description of score). The provider's physical or electronic signature must be in the medical record. Provider includes physician or non-physician practitioner, (i.e., Psychologist, Physician Assistant, Certified Registered Nurse Practitioner, and Certified Pediatric Nurse Practitioner). If a standardized tool has a summary form, the summary must be retained/scanned into the medical record. For any other form with no summary, retain/scan the full document.

Objective Developmental Testing

Added: Objective Developmental Testing…memory and/or executive

Objective developmental testing is when a physician or other health care professional measures cognitive, motor, social, language, adaptive, and/or cognitive abilities using provider standardized tests (meeting industry standards) via written, oral, or combined format testing. The following codes apply to testing for developmental disorders for recipients up to 20 years old and must include the interpretation and report on the findings.

A. Procedure Codes:

1. 96112 – Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive

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functions by standardized developmental instruments) when performed by physician or other qualified healthcare professional, with interpretation and report; first hour

Added: functions by standardized …post-payment review.

- Report 96112 for the initial hour of testing, with interpretation and report.
- 96112 may not be reported for less than 31 minutes of time.

2. 96113 – Each additional 30 minutes (list separately in addition to code 96112)

- Report 96113 for each additional 30 minutes, with interpretation and report.
- 96113 may not be reported for less than 16 minutes.

B. Documentation Requirement:

1. Generally, the documentation of objective developmental testing will include: scoring, interpretation, and preparation of a separate identifiable report.

- The report must include the following: identifying data, date/time and location of testing, reason for the type of testing being done, and titles of all instruments completed by the child.
- The report must also include the test protocol, all scoring sheets, and the scored item results.
- The provider's interpretation and plan need to be noted in the report.

2. An appropriate provider signature and date is required according to Alabama Administrative Code Rule 560-X-1-.18.

3. The total time spent on these services for the patient is required. If time is not documented, the code(s) may not be reported.

- If the testing is performed over several days, the time for all testing should be combined and reported on the last day of service.

C. These services will be subject to post-payment review.

Brief Emotional and Behavioral Assessment

EPSDT providers are allowed to bill for an emotional and behavioral assessment in addition to an EPSDT screening for ages 3 months to 20 years. EPSDT providers also have the option of providing the emotional and behavioral assessment anytime that surveillance (medical history of risk factors, parental/caregiver concern) identifies a need. Providers are encouraged to use standardized tools that have a moderate to high sensitivity, specificity and validity level and are culturally sensitive. The following code, which is limited to three (3) units per date of service (three different screening tools used), may be used to bill for this screening:

> 96127 – Brief emotional/behavioral assessment (e.g., depression inventory, attention-deficit/hyperactivity disorder [ADHD] scale), with scoring and documentation, per standardized instrument (Provider must document description of score).

Examples of screening tools allowed for this code include, but not limited to:

- Ages and Stages Questionnaire/ Social Emotional (ASQ-SE)
- Modified Checklist for Autism in Toddlers (M-CHAT)
- NICHQ Vanderbilt Assessment Scales
- Behavior Assessment Scale for Children Second
- Patient Health Questionnaire (PHQ – 2 AND PHQ – 9)

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- Pediatric Symptom Checklist (PSC)

The emotional and behavioral assessments must be ordered by the provider or on behalf of the provider based on emotional and behavioral assessment written protocol/standing orders and scored Provider must document description of score). The provider's physical or electronic signature must be in the medical record. Provider includes physician or non-physician practitioner, (i.e., Psychologist, Physician Assistant, Certified Registered Nurse Practitioner, and Certified Pediatric Nurse Practitioner). If a standardized tool has a summary form, the summary must be retained/scanned into the medical record. For any other form with no summary, retain/scan the full document.

Vision Testing/Screenings

Vision screenings are available either as a result of the EPSDT referral or as a result of a request/need by the recipient. A subjective screening for visual problems must be performed on children from birth through age two by history and observation. Gross examinations should be documented as grossly normal or abnormal. Objective testing begins at age three. Visual acuity screening must be performed through the use of the Snellen test, Allen Cards, photo refraction, or their equivalent. Objective testing must be referred out if not performed by the screening provider.

If a child is uncooperative, perform a subjective assessment. The reason(s) for not being able to perform the test must be documented in the medical record. Proceed with billing the vision screening on the same date of service as the initial or periodic screening. The child should be rescheduled for an appointment to complete the vision screening. Be sure to complete the vision screening within 30-45 days from the original screening date.

If a suspected visual problem manifests itself, regardless of whether such services coincide with the periodicity schedule, an interperiodic screening should be scheduled with the child's physician so the history and problem-focused physical exam, can be obtained and an EPSDT referral issued to the appropriate specialist or consultant.

Providers **must** use an "EP" modifier to designate all services related to EPSDT well-child visits, **including routine vision** and **hearing screenings**. Post payment reviews are performed to determine appropriate utilization of services.

Trained office staff may perform a vision screening if successfully trained. A staff member must meet the following criteria to be considered trained.

- Employee observes a vision screening being performed on a minimum of three patients by a skilled/trained employee
- Employee verbalizes an understanding of the steps required to perform a vision screening
- Employee performs a vision screening under supervision on a minimum of three patients successfully.

Hearing Testing/Screenings

Hearing screenings are available either as a result of an EPSDT referral or as a result of a request/need by the recipient. A subjective screening for hearing problems must be performed on children from birth through age four by history and observation. Gross examination should be documented as grossly normal or abnormal. Objective testing begins at age five. Hearing screenings must be performed through the use of a

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pure tone audiometer at 500 and 4,000 Hz at 25 decibels for both ears. If a child fails to respond at either frequency in either ear, a complete audiogram must be done. Objective testing must be referred out if not performed by the screening provider.

If a child is uncooperative, do a subjective assessment. The reason(s) for not being able to complete the test must be documented in the medical record. Proceed with billing the hearing screening on the same date of service as the initial or periodic screening. The child should be rescheduled for an appointment to complete the hearing screening. Be sure to complete the hearing screening within 30-45 days from the original screening date.

If a suspected hearing problem manifests itself, regardless of whether such services coincide with the periodicity schedule, an interperiodic screening should be scheduled with the child's physician so the history and problem-focused physical exam can be obtained and an EPSDT referral issued to the appropriate specialist or consultant.

Trained office staff may perform a hearing screening if successfully trained. A staff member must meet the following criteria to be considered trained.

- Employee observes a hearing screening being performed on a minimum of three patients by a skilled/trained employee
- Employee verbalizes an understanding of the steps required to perform a hearing screening
- Employee performs a hearing screening under supervision on a minimum of three patients successfully.

EP modifiers are used when billing initial, periodic and interperiodic screenings. Once chronic problems have been identified, providers should bill the appropriate level of office visit code and bill the services as EPSDT referring.

Dental Services

Dental care is limited to Medicaid-eligible individuals who are eligible for treatment under the EPSDT Program. Dental screenings must be performed on children from birth through age two by observation/inspection and history. Beginning with age one, recipients must be either under the care of a dentist or referred to a dentist for dental care.

A periodic oral examination is recommended once every six months for eligible Medicaid recipients under 21 years of age. Dental services include emergency, preventive, and therapeutic services as well as orthodontic treatment when medically necessary. A referral, or documentation that recipient is under the care of a dentist is required at age one and older. Follow-up is no longer mandatory. Any time a need for dental care is identified, regardless of the child's age, the child should be referred to a dentist.

Beginning with age one, providers should educate and document that caretakers have been advised of the importance (anticipatory guidance) of good oral healthcare and the need to make a dental appointment. Additional documentation suggestions include providing the caretaker with one of the following: www.insurekidsnow.gov, or the Recipient Hotline number to assist with locating a dentist (800) 362-1504.

Effective 01/01/2009, Pediatric providers (MDs, DOs, PAs, and NPs) are be able to bill in accordance with Medicaid reimbursement policies for oral assessment and application of fluoride varnish for recipients age 6 months through 35 months of age. Providers may bill assessment code D0145 (oral exam less than 3 years old,

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counseling with primary caregiver). D0145 can be billed once by pediatric medical provider and once by the dental provider for recipients 6 months through 35 months of age. Varnishing code D1206 (topical fluoride application) will be limited to 3 per calendar year, not to exceed a maximum of 6 fluoride varnish applications between 6 months and 35 months of age. Frequency is not allowed less than 90 days. Providers are required to bill ICD 10 diagnosis code Z13.84 or Z29.3 on or after October 01, 2015.Once a recipient has an established dental home (described in Chapter 13), a pediatrician cannot bill D1206.

Dental care under the Program is available either as a result of the EPSDT referral or as a result of request/need by the recipient. Conditions for each situation are as follows:

1. EPSDT Referral – If the EPSDT Screening Provider determines a recipient requires dental care or if the recipient is age one or older and is not currently under the care of a dentist, the recipient must be referred to an enrolled dentist for diagnosis and treatment. After the recipient's dental care is initiated, the consultant's portion of the Referral Form (Form 362) must be completed by the dentist and the appropriate copy must be returned to the screening provider.
2. Recipient Seeking Treatment – If a recipient who has not been screened through the EPSDT Program requires dental care, care may be provided without having a Referral Form. Dental care provided on request of the recipient is considered a partial screening. In this situation, after the required care is completed, the dentist should advise the recipient to seek an EPSDT screening provider to obtain a complete medical assessment.

NOTE:

Dental health care services are available for eligible children under age 21, as part of the EPSDT program. To obtain information about dentists. Please contact Provider Assistance Center at (800) 688-7989.

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Laboratory Screenings

Laboratory screening procedures must be performed in coordination with other medical screening services at the same visit, whenever possible. If verifiable results are available from another provider that any required laboratory procedure was performed within 30 days prior to the screening visit and there is no indication of a diagnosis that would warrant that the test be redone, it is not necessary to perform the test again. However, the test results or a copy of the test results should be documented in the medical record.

NOTE:

Providers have the option of obtaining the Hgb or Hct and the lead test during the nine month or twelve month well child visit (EPSDT screening).

The following is a list of tests and procedures of laboratory screenings:

Laboratory Test	***Description***
Newborn Screening	Newborn screening is mandated by **Statutory Authority Code of Alabama 1975, Section 22-20-3**. Every hospital or facility providing delivery services is required to screen all infants for these potentially devastating disorders. The Alabama Department of Public Health (ADPH) is responsible for administrative oversight of the Newborn Screening Program. Infants are screened for 32 primary and 45 secondary disorders which include Endocrine Disorders (Congenital Hypothyroidism and Congenital Adrenal Hyperplasia), Cystic Fibrosis (CF), Sickle Cell Disease, Hearing Loss, Metabolic Disorders (Amino, Fatty, and Organic Acid), severe combined immunodeficiency (SCID), spinal muscular atrophy (SMA), and critical congenital heart disease through pulse oximetry screening. The Alabama Newborn Screening website has a complete list of disorders at www.alabamapublichealth.gov/newbornscreening. Early diagnosis of these conditions may reduce morbidity, premature death, intellectual disability, and other developmental disabilities. All initial screening tests are conducted by ADPH's Bureau of Clinical Laboratories (BCL). Infants 12 months of age and younger with no record of a newborn screen should be tested as soon as possible. Screening for hemoglobinopathies (sickle cell disease/trait or thalassemia) is only included on the initial newborn screen. If initial results are not satisfactory for infants from birth to 12 months of age a repeat test must be performed. Children over 12 months of age who have never been tested need only be screened when ordered by a physician. ADPH's BCL has established standards and cutoffs for newborns and infants, and therefore, **cannot accept specimens on infants older than 12 months of age**. Please see the Newborn Screening Collection Guidelines at https://www.alabamapublichealth.gov/newbornscreening/assets/newbornscreeningbloodcollectionguidelines.pdf Routine second testing is recommended between two and six weeks of age, with four weeks being optimal. This second screen is critical in detecting a condition that may not have been picked up on an initial screen. Confirmation of abnormal newborn screening results is always necessary. An infant with a positive screen should be referred for diagnostic testing. The Alabama Newborn Screening Program works in partnership with pediatric sub-specialists to ensure all babies identified with abnormal results receive appropriate follow-up. These specialists are located at the University of Alabama in Birmingham (UAB), University of South Alabama in Mobile, and the St. Jude Clinic

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Laboratory Test	*Description*
	in Huntsville. In addition, there are seven community-based Sickle Cell Organizations who provide counseling and follow-up for infants identified with sickle cell disease and trait. The Cystic Fibrosis Care Center at UAB provides CF care to include genetic counseling at Children's of Alabama. It should be noted physicians should not bill for laboratory tests performed by the BCL. However, procedure codes 36415 and 36416 with modifier 90 may be billed for the specimen collection when referred to an outside laboratory. All screening tests are conducted by Alabama Department of Public Health's Bureau of Clinical Laboratories.
Public Health: Secure Remote Viewer (SRV)	The Secure Remote Viewer (SRV) is a web-based system that allows healthcare providers access to newborn screening results. The system allows users to search, view, and print results immediately from their computer. SRV is offered by the Alabama Department of Public Health, Bureau of Clinical Laboratories (BCL). The SRV provides 24-hour, seven days a week web-based reporting of screening results. The SRV requires registration with the BCL. Physicians may register with the system by completing the registration form found at https://www.alabamapublichealth.gov/newbornscreening/assets/srv_registration_form.pdf. Each physician is required to provide his/her state license number, national provider identifier (NPI), and an email address. On the registration form, physicians are asked to provide three options for the account's username. Once registration is complete, the registrant will receive a username and password via the email account provided. The email will not include the link to the SRV website for security purposes. For additional questions or information, visit https://www.alabamapublichealth.gov/newbornscreening/assets/srvregistration-instructions_lab_10-23-2023.pdf or call the BCL at (334) 290-3097.
Iron Deficiency Anemia Screening	Hematocrit and/or hemoglobin values must be determined at a medical screening visit by 9 months of age. Providers have the option of obtaining the lead and Hct/Hgb at nine or twelve months of age. Hematocrit and/or hemoglobin must also be determined between 11-20 years of age. Any other time must be deemed medically necessary based on physical examination and nutritional assessment.
Urine screening	Effective 10/01/2008 the urinalysis component of an EPSDT screening is no longer a requirement. A urinalysis should only be performed if clinically indicated. If a urinalysis is needed, 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 also be checked for leukocytes.
Chlamydia Screening	Chlamydia Screening is recommended for all sexually-active females aged <25 years annually.

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NOTE:

The hgb or hct are included in the screening reimbursement and should not be billed separately.

Laboratory Test	*Description*
Lead toxicity screening	All children must have a blood lead toxicity screening at 12 and 24 months of age. Providers have the option of obtaining the lead and Hct/ Hgb at 9 or 12 months of age. A lead toxicity screening is also required for any child 36 to 72 months of age who has not previously received a blood lead toxicity screening or who presents with symptoms of possible lead poisoning. All children should receive lead toxicity screenings since all children are vulnerable to blood lead poisoning. Children's blood lead levels increase most rapidly at 9-12 months of age and peak at 18-24 months of age. The screening test of choice is blood lead measurement (replaces the erythrocyte protoporphyrin (EP) test.
Other lab tests	There are several other tests to consider in addition to those listed above. Their appropriateness is determined by an individual's age, sex, health history, clinical symptoms, and exposure to disease. These may include, for example, a pinworm slide, urine culture, VDRL, GC cultures and stool specimen for parasites, ova, and blood. **Note:** The test for VDRL, gonorrhea cultures, intestinal parasites, and pinworms may be done by the Alabama Department of Public Health clinical laboratory at NO cost to the EPSDT screening provider. The State lab slip must have "EPSDT Program" documented across the top. Other Medicaid approved laboratories may be used to run sickle cell and lead screening tests.

NOTE:

The State Laboratory will supply microvettes, mailing containers and forms for obtaining blood lead levels at no cost to providers upon request. Please contact (334) 290-6130 to obtain additional information.

Public Health Department Services

EPSDT care coordination is initiated for children with a confirmed blood lead level of > 3.5 μg/dL. Case management services may be requested if the physician determines the family requires additional education in the home. A physician's order is required. EPSDT care coordinators assess the family's social and environmental needs, develop a case plan with the goal of reducing blood lead levels, educate family regarding lead risk behaviors, schedule blood lead level retest, and refer to appropriate resources regarding lead screening guidelines. An environmental investigation is initiated for children with a confirmed venous blood lead level of ≥ 15 ug/dL or may be requested through a physician's order. Environmentalists perform an environmental investigation on a residence to identify lead hazards and recommend interim control or abatement measures if necessary.

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Blood Lead Screening and Management Guidelines

Screening Guidelines

All children should receive blood lead level (BLL) screenings at 12 and 24 months of age. Providers have the option obtaining the lead level and Hct or Hgb at 9 or 12 months of age.

A BLL screening is also required for a child who:

- Is 36 to 72 months of age and has not previously received a BLL screening.
- Has a change in risk status.
- Presents with symptoms of possible lead poisoning. (Examples: severe anemia, seizures, constipation, abdominal pain, changes in behavior.)

Lead Risk Assessment Questionnaire

Providers should assess a child's risk of blood lead poisoning beginning at 9 month of age. Children determined to be at high risk of blood lead poisoning should receive parental education, nutritional counseling, and a BLL screening as appropriate. Administering the Risk Assessment Questionnaire instead of a BLL screening does not meet Medicaid requirements. A venous specimen is preferred, although capillary samples are acceptable.

BLL (ug/dL)	COMMENTS
5-9	CONFIRM with venous sample within **3 months**
10-14	CONFIRM with venous sample within **3 months**
15-19	CONFIRM with venous sample within **1 months**
20-44	CONFIRM with venous sample within **5 days**
45-59	CONFIRM with venous sample within **48 hours**
60-69	CONFIRM with venous sample within **24 hours**
>70	CONFIRM with venous sample **immediately**

Venous Samples - Confirmed Diagnostic Comments

< 5	• EDUCATE families about preventing lead exposure • SCREEN BLL at 12 and 24 months of age, or as indicated by risk status.
5-9	• OBTAIN confirmatory diagnostic (venous) test within 3 months, even if the initial sample was venous. • CONTINUE follow-up testing every 3 months until 2 consecutive tests are < 5 µg/dL. • EDUCATE families concerning lead absorption and sources of lead exposure (ADPH pamphlet available). Case management services • EXPLAIN that there is no safe level of lead in the blood. • PROVIDE nutritional counseling. • COMPLETE history and physical exam. • TEST for anemia and iron deficiency. • PROVIDE neurodevelopmental monitoring. • SCREEN all siblings under age 6. • OBTAIN abdominal X-ray (if particulate lead ingestion is suspected) with bowel decontamination if indicated.
10-14	• REFER for targeted case management and environmental investigation via mailing ADPH-FHS 135, *Elevated Blood Lead Environmental Surveillance Form,* to the address on the bottom of the form within 5 days of notification

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	of results. • PROVIDE parental education and nutritional counseling. • RETEST within 3 months with venous sample.
15-19	• REFER for targeted case management and environmental investigation via mailing ADPH-FHS-135, *Environmental Surveillance Form,* to the address on the bottom of the form within 5 days of notification of results. • PROVIDE parental education and nutritional counseling. • RETEST within 3 months with venous sample.
20-44	• REFER for targeted case management and environmental investigation via mailing ADPH-FHS-135, *Environmental Surveillance Form,* to the address on the bottom of the form within 3 days of notification of results. • PROVIDE parental education and nutritional counseling. • RETEST within 3 months with venous sample or more often as determined by physician.
45-59	• REFER for treatment (chelation therapy*) to physician within 24 hours if asymptomatic; otherwise, refer for medical treatment immediately. • REFER for targeted case management and environmental investigation via faxing ADPH-FHS-135, *Environmental Surveillance Form,* to 334-206-2983 immediately upon notification of results. • PROVIDE parental education and nutritional counseling. • RETEST within 1 month with venous sample or more often as determined by physician.
60-69	• REFER for treatment (chelation therapy*) to physician with 24 hours if asymptomatic; otherwise, refer for medical treatment immediately. • REFER for targeted case management and environmental investigation via faxing ADPH-FHS-135, *Environmental Surveillance Form,* to 334-206-2983 immediately upon notification of results. • PROVIDE parental education and nutritional counseling. • RETEST within 2 weeks with venous sample or more often as determined by physician.
>70	• REFER for treatment (chelation therapy*) to physician within 24 hours if asymptomatic; otherwise, refer for medical treatment immediately. • REFER for targeted case management and environmental investigation via faxing ADPH-FHS-135, *Environmental Surveillance Form,* to 334-206-2983 immediately upon notification of results. • PROVIDE parental education and nutritional counseling. • RETEST weekly with venous sample or more often as determined by physician.

***Child should only return to a lead-safe environment after chelation therapy.**

CLINICAL NOTE:

Most children with lead poisoning are asymptomatic. Symptomatic children with elevated blood lead levels should be evaluated immediately. Symptoms may include coma, seizures, bizarre behavior, ataxia, apathy, vomiting alteration of consciousness, and subtle loss of recently acquired skills. Lead encephalopathy has been reported with levels as low as 70 µg/dL.

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Environmental Lead

Environmental Lead Investigations is the investigation of the home or primary residence of an EPSDT-eligible child who has an elevated blood lead level. Please refer to Chapter 101, County Health Departments, for more information.

Normal and Abnormal Diagnoses

An abnormal diagnosis should only be billed when a health problem is identified and is referred for further diagnosis and treatment services. These services may be self-referrals.

A normal diagnosis should be billed when no health problem is identified or when identified health problems are treated immediately (acute or one time problem) during the screening (same day) and no referral is made for further diagnosis and treatment services. A normal diagnosis should also be billed when the only referrals are for *routine* vision, hearing or dental services. ICD 10 diagnosis Z00.12, Z76.1 and Z76.2 for age 29 days to 17 years and Z00.0, Z00.00 and Z00.01 for age 18+ on or after October 01, 2015.

Interperiodic Screenings

EPSDT-eligible children may receive medical, vision, hearing, and dental services that are medically necessary to determine the existence of a suspected physical or mental illness or condition, regardless of whether such services coincide with the periodicity schedule for these services. Screenings that are performed more frequently or at different intervals than the established periodicity schedules are called **interperiodic screenings**. An interperiodic screening may be performed before, between, or after a periodic screening if medically necessary. Interperiodic screenings are performed for undiagnosed medically necessary conditions outside the established periodicity schedule. Interperiodic EPSDT screenings are problem-focused and abnormal.

Interperiodic screening examinations may also 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, then further examination is medically necessary.

By performing an interperiodic screening and issuing an EPSDT referral form, physician office and other benefits will be “saved” for acute illnesses or other sickness. An interperiodic screening should be performed (where a history and problem-focused physical exam occurs) for suspected medical, vision, hearing, psychological, or dental problems in order for an EPSDT referral to be issued for further diagnosis and/or treatment. In this manner, the recipient will be referred for consultation and/or to a specialist for medically necessary and appropriate diagnostic tests and/or treatment. Vision/hearing screenings are to be performed/billed on the same date of service as an initial or periodic screening only. Vision/hearing screenings are limited to one each annually, beginning at age 3 for vision and 5 for hearing. However if a suspected vision/hearing/ dental/medical problem should manifest itself, an interperiodic screening should be performed in order for an EPSDT referral to be issued to a specialist or consultant. For more information regarding vision and hearing screenings, please refer to section A.3.5. For more information regarding dental screening and EPSDT referral requirements, please refer to Chapter 13 Dentist.

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

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professional who meets the qualifications for participation in the EPSDT program to be an interperiodic screen, regardless of whether the health care professional is enrolled as a provider with the Agency.

A health developmental or educational professional who comes in contact with the child outside the formal health care system may also determine whether an interperiodic screening is medically necessary. The screening provider must document the person referring the child, and a description of the suspected problem, in the record.

Documentation requirements for interperiodic screenings are:

- Consent
- Medical-surgical history update
- Problem-focused physical examination
- Anticipatory guidance/counseling related to the diagnosis made.

Interperiodic screenings must always be filed with the patient's other insurance first. If the primary insurance is a HMO or the provider is a FQHC, IRHC or PBRHC, the interperiodic screening code must be submitted. Once the claim has been paid/denied, Medicaid may then be billed utilizing the interperiodic screening code with an EP modifier appended. When filing for an interperiodic screening, always append an EP modifier or the visit will count against benefit limits.

If the primary insurance is not a HMO, bill the appropriate "office visit" code. Once the claim has been paid/denied from the patient's other insurance, a claim may be filed with Medicaid utilizing the same "office visit" code with an EP modifier appended. When billing an office visit code for an interperiodic code, always append the EP modifier or the visit will count against benefit limits.

NOTE:

If any other treatments are provided the same day (injections, lab, etc.), a "1" or "4" must also be reflected in Block 24h, on each line item, or the claim will deny.

NOTE:

The codes for interperiodic screenings **must be billed with an EP modifier and** are as follows:

- 99202 EP through 99215 EP for office and/or outpatient interperiodic screenings
- 99233 EP for Inpatient interperiodic screenings

The new interperiodic screening codes will count against office / hospital visit limits if billed without an EP modifier.

The Evaluation and Management code level of care chosen must be supported by medical record documentation.

Each child's primary insurance must be billed first, and then Medicaid as the payor of last resort.

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SCREENING CODES

PROCEDURE CODE	DESCRIPTION	Medicaid EPSDT Provider Rate (EP)
99381 EP EPSDT NEW PATIENT	NEW PATIENT UNDER 1 YEAR OF AGE	$ 70.00
99382 EP EPSDT NEW PATIENT	NEW PATIENT 1YEAR TO 4 YEARS OF AGE	$ 70.00
99383 EP EPSDT NEW PATIENT	NEW PATIENT 5 YEARS TO 11 YEARS OF AGE	$ 70.00
99384 EP EPSDT NEW PATIENT	NEW PATIENT 12 YEARS TO 17 YEARS OF AGE	$ 70.00
99385 EP EPSDT NEW PATIENT	NEW PATIENT 18 YEARS TO 20 YEARS OF AGE	$ 70.00
99391 EP EPSDT ESTABLISHED PATIENT	ESTABLISHED PATIENT UNDER 1 YEAR	$ 70.00
99392 EP EPSDT ESTABLISHED PATIENT	ESTABLISHED PATIENT 1 YEAR TO 4 YEARS OF AGE	$ 70.00
99393 EP EPSDT ESTABLISHED PATIENT	ESTABLISHED PATIENT 5 YEARS TO 11 YEARS OF AGE	$ 70.00
99394 EP EPSDT ESTABLISHED PATIENT	ESTABLISHED PATIENT 12 YEARS TO 17 YEARS OF AGE	$ 70.00
99395 EP EPSDT ESTABLISHED PATIENT	ESTABLISHED PATIENT 18 YEARS TO 20 YEARS OF AGE	$ 70.00
99202 EP INTERPERIODIC	NEW PATIENT OFFICE/OUTPATIENT VISIT, TOTAL TIME 15-29 MINUTES	$ 64.61
99203 EP INTERPERIODIC	NEW PATIENT OFFICE/OUTPATIENT VISIT, TOTAL TIME 30-44 MINUTES	$ 91.85
99204 EP INTERPERIODIC	NEW PATIENT OFFICE/OUTPATIENT VISIT, TOTAL TIME 45-59 MINUTES	$ 141.16
99205 EP INTERPERIODIC	NEW PATIENT OFFICE/OUTPATIENT VISIT, TOTAL TIME 60-74 MINUTES	$ 178.70
99211 EP INTERPERIODIC	ESTABLISHED PATIENT OFFICE/OUTPATIENT VISIT	$ 17.00
99212 EP INTERPERIODIC	ESTABLISHED PATIENT OFFICE/OUTPATIENT VISIT, TOTAL TIME 10-19 MINUTES	$ 31.00
99213 EP INTERPERIODIC	ESTABLISHED PATIENT OFFICE/OUTPATIENT VISIT, TOTAL TIME 20-29 MINUTES	$ 63.95

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PROCEDURE CODE	DESCRIPTION	Medicaid EPSDT Provider Rate (EP)
99214 EP INTERPERIODIC	ESTABLISHED PATIENT OFFICE/OUTPATIENT VISIT, TOTAL TIME 30-39 MINUTES	$ 93.11
99215 EP INTERPERIODIC	ESTABLISHED PATIENT OFFICE/OUTPATIENT VISIT, TOTAL TIME 40-54 MINUTES	$ 125.40

NOTE:

Effective 1/1/2011, periodic screening codes 99382 EP- 99385 EP and 99392 EP- 99395 EP may not be billed in a hospital setting (inpatient or outpatient facility settings).

Intensive Developmental Diagnostic Assessment

An EPSDT Intensive Developmental Diagnostic Assessment is a multidisciplinary comprehensive screening limited to infants' age zero to under two years, and is also limited to two per recipient per lifetime. These screenings are in addition to the routine periodic screenings and must be performed by a qualified EPSDT Intensive Developmental Diagnostic Assessment Screening provider, as approved and enrolled by Medicaid.

NOTE:

Medical necessity is subject to retrospective review by the Alabama Medicaid Agency. Please refer to Chapter 7, Understanding Your Rights and Responsibilities as a Provider, for more information.

Interagency Coordination

The State of Alabama, in conjunction with the Interagency Coordinating Council and the Alabama Department of Rehabilitation Services will implement a system of services to the eligible population (20 USC Section 1471 et seq, Part H), with the assistance of agencies, programs, providers, and the families of eligible infants and toddlers with special needs.

The Alabama Medicaid Agency is one of nine state agencies that hold positions on the Interagency Coordinating Council. The Early Intervention Law legislates a statewide system of early intervention services for eligible infants and toddlers that is comprehensive and coordinated among all disciplines and providers involved and encourages the development of a system of service delivery that includes parents' participation and input. Services that provide early intervention are to be coordinated across agency and provider lines.

The definition of a child eligible for early intervention services includes infants and toddlers under age three 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) have a diagnosed physical or mental condition which has a high probability of resulting in developmental delay. Early intervention services can include the following:

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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 provider to obtain the EPSDT screening information and any other pertinent information. In order to coordinate services, once a well child visit (EPSDT) has been completed and a developmental delay has been indicated, contact Child Find, (**800) 543-3098**. Please refer to the Early Intervention Child Find Referral Form at the end of this Appendix or visit Medicaid's website at: www.medicaid.alabama.gov. Additionally, please refer to https://www.rehab.alabama.gov/ for other rehabilitation services.

NOTE:

You may refer a family to Alabama's Early Intervention System (AEIS) in addition to referring the child and family to other appropriate services. AEIS staff is located in seven districts in the state. Please call the toll free number if you are interested in information about local EI resources.

Recommended Health Education Counseling Topics

2 weeks-3 months Nutrition - Spitting up Hiccoughs Sneezing, etc. Safety Need for affection Immunizations Skin and scalp care Bathing frequency How to use a thermometer When to call the doctor	**4-6 months** Nutrition Safety Teething and drooling/dental hygiene Fear of strangers Lead poisoning Immunizations
7-12 months Nutrition Immunizations Safety Dental hygiene Night crying Separation anxiety Need for affection Discipline Lead poisoning	**13-18 months** Nutrition Safety Immunizations Dental hygiene Temper tantrums Obedience Speech development Lead poisoning

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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 Tobacco Cessation 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 Tobacco Cessation 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.

Providers must provide age-appropriate health education related to smoking and smoking cessation. This includes risk-reduction counseling with regard to use during routine well-child visits. In addition to routine visits, additional counseling must be provided when medically necessary for individuals under age 21.

Billing Requirements

The table below provides billing information for EPSDT screening claims:

Topic	***Explanation***
Copayment	EPSDT recipients, under 18 years of age, are not subject to co-payments.
Prior Authorization	Screenings are not subject to prior authorization.
Referral	Please refer to Section A.4, Providing and Obtaining Referrals, for more information.
Time Limit for Filing Claims	One year from the date of service
Visit Limitations	Effective 05/08/2020 an office visit is now billable on the same day with an EPSDT screening by the same provider or provider group.
Diagnosis Codes	The *International Classification of Diseases - 10th Revision - Clinical Modification* (ICD-10-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, AMA Plaza 330 North Wabash Ave, Suite 39300 Chicago, IL 60611-5885, or 1-800-621-8335.
Procedure Codes and Modifiers	The following procedure codes should be used when billing comprehensive EPSDT screening services: • 99381;EP - 99385;EP: Initial EPSDT Screening • 99391;EP - 99395;EP: Periodic EPSDT Screening

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Topic	*Explanation*
	• 99173;EP: Vision Screening – Annual • 92551;EP: Hearing Screening – Annual Effective January 1, 2007, the interperiodic screening codes have changed. The following procedure codes (in service locations other than inpatient hospital) must be used: 99211;EP - 99215;EP EP modifiers are used when billing initial, periodic and interperiodic screenings. Once chronic problems have been identified, providers should bill the appropriate level of office visit code and bill the services as EPSDT referring. For interperiodic screenings performed in an inpatient hospital setting, the following procedure code must be used: 99231;EP – 99233;EP Interperiodic screening codes should also have abnormal diagnosis codes. The (837) Professional, Institutional and Dental electronic claims and the paper claim have been modified to accept up to four Procedure Code Modifiers.
Intensive Developmental Diagnostic Assessment (Multidisciplinary team) An HT modifier must be appended to procedure codes 96110, 96112 and 96113 to identify Intensive Diagnostic Assessment (Multidisciplinary team)	The following procedure codes should be used when billing for an intensive development diagnostic assessment (a multidisciplinary comprehensive screening) for children under two years of age (limited to two per recipient per lifetime) 96110;HT – Developmental testing; limited (eg, Developmental Screening Test II, Early Language Milestone Screen), with interpretation and report. (Formerly known as Intensive developmental diagnostic assessment, normal findings) 96112;HT – First hour 96113;HT – each additional 30 minutes Developmental testing; extended (includes assessment of motor, language, social, adaptive and/or cognitive functioning by standardized developmental instruments) with interpretation and report. (Formerly known as Intensive developmental diagnostic assessment, abnormal findings)
Third Party Coverage	Providers are required to file with available third party resources prior to filing Medicaid. Preventive pediatric services and prenatal care are excluded from this requirement unless the recipient has managed care coverage or Medicaid pays the provider a global fee.
Reimbursement	Governmental screening providers (including physicians) will be paid on a negotiated rate basis, which will not exceed their actual costs. Non-governmental screening providers will be paid their usual and customary charge, which is not to exceed the maximum allowable rate established by Medicaid.

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Topic	*Explanation*
EPSDT Indicator Reference	The EPSDT Indicator will be either a “Y” or “N”, as applicable, when using electronic claims only. Providers should bill the appropriate level visit code and bill the services as EPSDT referring for chronic problems that have been identified. This EPSDT Indicator will allow care to be rendered and bypass the 14 or 16 visit limits.

NOTE:

Well child visits (Initial, Periodic, and Interperiodic screenings) do not count against recipient's benefit limits of 14 physician office visits per calendar year when billed with the EP modifier. There is no co-pay for recipients under 18 years of age.

A.3.7 ACHN, Primary Care Case Management (PCCM) Referral Services

Please refer to Chapter 40 for more information regarding the ACHN program.

A.3.8 Billing for ACHN Referred Services

Please refer to Chapter 40 for more information regarding the ACHN program.

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A.4 Providing and Obtaining Referrals

One of the primary purposes of the EPSDT services is to ensure that health problems are diagnosed and treated early before they become more complex and their treatment more costly. A Medicaid eligible child who has received an EPSDT screening may receive additional medically necessary health care. These services are considered above the normal benefit limitations and require a referral from an EPSDT screening provider. Some of these referred services require prior authorization from the Alabama Medicaid Agency. The Alabama Medicaid Referral Form (Form 362) must be appropriately completed by the screening physician including the screening date that the problem was identified and the reason for referral.

Providers are not required to complete written referrals to the other providers in the same group. The medical record documentation shall clearly indicate that the PCP did a screening, identified the problem, and an appropriate referral was made.

Referrals to specialists and other physicians outside of the group are required to have a written referral.

A cascading referral is used in situations where more than one consultant may be needed to provide treatment for an identified condition(s). When this situation arises, the original referral form is generated by the EPSDT screening provider. If the first consultant determines a recipient should be referred to another consultant/specialist, it is the first consultant's responsibility to provide a copy of the referral form to the second consultant. This process is continued until the condition(s) have been rectified or in remission, or referral expires, at which time a new screening and referral must be obtained. A new approval/EPSDT screening must be provided anytime the diagnosis, plan of care (care plan, plan of treatment, treatment plan, etc.), or treatment changes. The consultant must contact the PCP for a new referral/screening at that time.

Medical documentation must be present in the recipient's medical record identifying the provider making referrals between consultants. Medical documentation created as a result of a referral between consultants must be associated with the original referral.

If a child is admitted to the hospital as a result of an EPSDT screening, the days will not count against the yearly benefit limit. Facility fees for outpatient visits will not count against the yearly benefit limit if the visit is the result of an EPSDT screening and referral. Services rendered by speech and occupational therapists are covered **only** as the result of an EPSDT screening.

Signature Requirement for Referrals: Effective May 16, 2012:

For hard copy referrals, the printed, typed, or stamped name of the primary care physician with an original signature of the physician or designee (physician or non-physician practitioner) is required. **Stamped or copied signatures will not be accepted**. For electronic referrals, provider certification is made via standardized electronic signature protocol.

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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 must refer the child without delay for further evaluation of the child's health status. Follow-up is required to assure that the child receives a complete diagnostic evaluation. Diagnostic services may include but are not limited to physical examination, developmental assessments, psychological and mental health evaluation, laboratory tests and any x-rays. Diagnosis may be provided at the same time, or it may be provided at a second appointment. For services such as physical therapy, speech therapy, and occupational therapy that require physicians' orders, all orders must be written according to practice guidelines and state/federal law and must include the date and signature of the provider, the service(s) ordered, and the recipient's name. The EPSDT referral form may be considered the physician's order as long as these guidelines are met. The physician's order/prescription date is considered "today's date" on the referral form.

The time limit for completing the referral form (Form 362) requires the form to be completed within 364 days of the date of the screening. If an abnormality or condition is noted during an EPSDT screening and an EPSDT referral form is not issued at the time (for example, sickle cell remission), an EPDST referral may be issued at a later date for the same diagnosis only (for example, sickle cell remission changes to sickle cell crisis). In this instance, the date utilized on the referral form will be the same as the date of the EPSDT screening where the abnormality/condition was noted. If another abnormality or condition occurs that was not diagnosed during an EPSDT screening, or if a condition has changed sufficiently so that further examination is medically necessary, an interperiodic screening should be performed (or periodic screening if it is due) to identify the problem.

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EPSDT referrals are valid for **one year from the date of the EPSDT screening**. Therefore, the maximum time an EPSDT referral remains valid is 12 months from the date of the EPSDT screening. The EPSDT screening date must be current to be valid. The EPSDT screening date may not be backdated or future dated. The date of the EPSDT screening should be documented under “Type of Referral” on form 362, the Alabama Medicaid Agency Referral Form. The EPSDT screening date documented on the Referral Form is the date used to determine the length of time an **EPSDT referral is valid**. The “Length of Referral” is used to determine the amount of time the referral is valid from the referral date and is inclusive of all types of referrals (EPSDT referral, Targeted Case Management, etc). Please refer to Appendix E, Medicaid Forms, for additional information.

Diagnosis and treatment services may be provided by the screening provider (self-referral) or may be obtained by referral to any other practitioner or facility qualified to evaluate, diagnose, or treat the child's health problem.

NOTE:

The number of visits or months must be documented on the EPSDT referral form to be considered a valid referral.

A.4.3 Treatment

Treatment may include but is not limited to physicians' or dentists' services, optometrists' services, podiatrists' services, hospital services (inpatient and outpatient), clinic services, laboratory and X-ray services, prescribed drugs, eyeglasses, hearing aids, prostheses, physical therapy, rehabilitation services, psychological services, and other types of health care and mental health services.

If a condition requires a referral, it is the responsibility of the screening provider and PCP, if applicable, to:

- Document the abnormality discovered during the EPSDT screening in the record
- Determine what resources a child needs and to which provider he/she wishes to be referred (the recipient's freedom of choice of providers must be ensured)
- Make the appropriate referral in a timely manner
- Offer and provide assistance in scheduling the appointment
- Verify whether the child received the service. Referrals must be followed up within 30 days (excluding dental) from the date of the appointment with the consultant.

A.4.4 Completing the Referral Form

The Referral for Services Form 362 must be completed after a screening if further diagnosis and/or treatment are required for a child not assigned to a PCP. The referral form is completed when referring the recipient to other providers for services that were identified during the screening as medically necessary.

Refer to Appendix E, Medicaid Forms, for a sample of the Alabama Medicaid Agency Referral Form.

Screening providers must include their 10-digit National Provider Identifier (NPI), name, and address for all recipients.

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- The **screening provider** must document the time span in which the referral is valid. The maximum time span is 12 months from the date of the screening.
- The **consulting provider** must follow the appropriate billing instructions and guidelines for completion of the CMS 1500 claim form found in Chapter 5, Section 5.2.2 of the Alabama Medicaid Provider Manual.

NOTE:

Providers should write the referral as soon as the condition is noted so that the regular benefits are not exhausted. This is important for patients with chronic conditions or a problem that will require numerous visits to treat.

EP modifiers are used when billing initial, periodic and interperiodic screenings. Once chronic problems have been identified, providers should bill the appropriate level of office visit code and bill the services as EPSDT referring.

Once benefit limitations have been exceeded, Medicaid will not pay for services without the EPSDT referral.

The referral form should follow the recipient for all services related to the condition noted on the form. If a child is screened with a particular condition noted and referred for further diagnosis, and another condition develops that is not noted on the referral form, the child must be re-screened in order to receive expanded benefits for the second condition noted. If not re-screened, the services rendered would count against the child's routine benefit limits.

NOTE:

If the screening provider refers a child to a consultant, it is the screening provider’s responsibility to follow up. However, if the managed care provider refers the child to a consultant, it is the managed care provider’s responsibility to follow up.

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A.4.5 EPSDT Referrals for ACHN Recipients

Scenario: A child is referred by the PCP to be screened by a county health department and appears to have a foot deformity.

Procedure: The child **must** be seen by a screening provider (a pediatrician credentialed as a screening provider: for example) to obtain an EPSDT referral form. The PCP may choose to

- Provide the necessary treatment
- Refer the child to an orthopedic specialist
- Instruct the screening provider to complete the referral form

The screening provider must complete the Alabama Medicaid Agency Referral Form (Form 362) if referring the child to a specialist. The referring number reflects the NPI of the screening provider.

The name and address of the screening provider should be entered to reflect, in this scenario, the county health department. All services in this scenario are covered by the original EPSDT screening referral, which must follow the child from visit to visit. The screening NPI and signature will reflect the county health department number and the signature of the health department employee who performed the screening.

The consulting provider must use the screening provider number as the referring physician on the claim form. Each provider testing the condition diagnosed during the screening, and documented in the referral, must include the screening/referring provider's number on the claim form. Please refer to Chapter 5, Filing Claims, for instructions on including the referring NPI on the claim form.

In this scenario, the specialist may suggest surgery, braces, and/or therapy. All services approved by and referred by the screening provider would then be covered by an EPSDT screening referral.

NOTE:

The PCP must be contacted and approve any and all referrals made by the specialist.

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A.4.6 Billing Instructions for Referred Services

For EPSDT Referred Services

If you file hard copy claims on the **UB-04**, you must complete the following fields:

- Block 2 – Enter the screening provider's 10-digit National Provider Identifier (NPI)
- Block 24 – Enter "**A1**" to indicate EPSDT

If you file **electronically** on the UB-04 (837 Institutional) using Gainwell *Provider Electronic Solutions* software, please refer to the latest edition of the Provider Electronic Solutions User Manual.

If you file claims on the **CMS-1500**, you must complete:

- Block 17 – Enter the name of screening provider
- Block 17a – Enter the screening provider's 10-digit National Provider Identifier (NPI)
- Block 24H – Enter "**1**" to indicate EPSDT

If you file **electronically** on the CMS-1500 (837 Professional) using Gainwell *Provider Electronic Solutions* software, please refer to the latest edition of the Provider Electronic Solutions User Manual.

For EPSDT Referred Services

If you file claims on the **UB-04**, you must complete:

- Block 2 – Enter the referring PCP's 10-digit National Provider Identifier (NPI)
- Block 24 – Enter "**A1**" to indicate EPSDT and managed care

If you file electronically on the UB-04 (837 Institutional) using Gainwell *Provider Electronic Solutions* software, please refer to the latest edition of the Provider Electronic Solutions User Manual.

If you file claims on the **CMS-1500**, you must complete:

- Block 17 – Enter the name of referring PCP
- Block 17a – Enter the referring PCP's 10-digit National Provider Identifier (NPI)
- Block 24H – Enter "**4**" to indicate EPSDT and managed care

If you file **electronically** on the CMS-1500 (837 Professional) using Gainwell *Provider Electronic Solutions* software, please refer to the latest edition of the Provider Electronic Solutions User Manual.

NOTE:

Each line item on the CMS-1500 Claim Form must have an indicator in Block 24 or 24H if billing for a Referred Service.

For Example: If the first line is an office visit and the indicator in Block 24 Or 24H is a "4", All additional services for that Date Of Service must also have an indicator of "4" in Block 24 Or 24H or the claim will deny.

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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 the ACHN, it is the ACHN's responsibility for overall care coordination. These ongoing activities include scheduling, coordinating, follow-up, and monitoring necessary EPSDT screening and other health services.

Care coordination enhances EPSDT Program efficiency and effectiveness by assuring that needed services are provided in a timely and efficient manner and that duplicated and unnecessary services are avoided.

A.4.7 Consent Forms

Since EPSDT screenings are voluntary services, some parents of children may decline a screening. This does not preclude the child from receiving a screening at a later date or receiving medically necessary diagnosis, treatment or other health services separate from the screening, providing such services do not exceed normal benefit limitations.

A "Consent for Services" form must be signed at each visit by the responsible adult. The consent could be a permission form to treat or a signature reflecting the date the service is rendered (e.g., a sign-in sheet). The consent for services should be filed in the patient's permanent medical record. If a sign-in logbook is used, the provider will need to keep this record for a minimum of three years plus the current year. The responsible adult must be present at the time of the screening to give pertinent history and developmental status and to receive counseling as indicated. The absence of a responsible adult as defined above would invalidate the screening. When off-site screenings are performed, the parent may complete the history form prior to the screening in compliance with Off-Site Screening Protocol. Recipients 14 years of age or older may sign for themselves.

A.4.8 Medical Records

All screening providers must maintain complete records for three years plus the current year on all children who have received services or screened. Records of all EPSDT-eligible children must be made available to Medicaid upon request. Medicaid will monitor EPSDT services provided by screening physicians or agencies on a periodic basis. If Medicaid identifies claims paid where any three findings listed as critical components of the screening process are omitted, the claim may be adjusted.

Medical records must include the following documentation. The critical components of a well child visit (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

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- * 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 screening needs to be performed only if clinically indicated (Effective 10/01/2008).
- * Lead testing/results (according to age)
- Tb skin test
- Height, weight, temperature, pulse, and blood pressure
- * Vision and hearing assessment/testing (Considered as two critical components)
- * Documentation of the unclothed physical examination
- * Dental referral/status for recipients 1 year of age and above
- * Failure to make appropriate referral, when required (i.e., medical, vision, hearing)
- * Referral follow-up on conditions related to medical, vision, or hearing problems

A.5 Off-site Screenings

Children are our state's most important assets and yet many of them arrive at school generally in poor health. The healthier a child, the greater his or her learning potential. The Alabama Medicaid Agency is committed to helping ensure that children are healthy and ready to learn. To that end, the Alabama Medicaid Agency has developed protocols for off-site EPSDT screenings. These services must be accessible to all children, not just Medicaid-eligible children.

NOTE:

EPSDT screening providers must also contact the recipient's primary care physician 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

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county or within 15 miles of the county in which the off-site screenings occur. Medical personnel performing the physical examination are limited to physicians, certified registered nurse practitioners (CRNP), certified nurse midwives (CNM), physician assistants (PA), and registered nurses (RN) employed by the facilities listed above.

Clinic is defined as a certified medical facility, under the supervision of a physician that provides a full range of medical services on a regular basis. A clinic must be equipped to handle acute care situations and provide treatment and/or management of chronic diseases. Licensed medical personnel must perform medical services.

Medical facility is defined as a Federal/State certified clinic, hospital, physician's office, or a DPH clinic where diagnosis of health problems are rendered and treatment of diseases occur. The medical facility must have a permanent location, regularly scheduled hours of operation, and a published telephone number. Medical services and supplies must also be available for treatment of abnormal conditions identified at the time of an EPSDT screening.

Physician's office is defined as a place staffed by physician(s) and other medical professionals where medical activities, such as the practice of medicine, is conducted. This office is specifically designed and set up to provide medical diagnosis and treatment of medical conditions. This office is open and operating on a published, regularly scheduled basis with a published telephone number and regularly scheduled appointments.

A.5.1 Enrollment for Off-site providers

To be considered as an EPSDT screening provider for off-site screenings, potential providers must submit the following criteria:

- A letter documenting the ability to complete all components of a screening. The physical exam portion of the screening must be completed by an approved EPSDT screening provider: physician, nurse practitioner, physician assistant, or a registered nurse. All registered nurses, except BSNs, must complete a Medicaid-approved Pediatric Assessment course or show proof of having completed a similar program of study in their professional training that prepared them to perform pediatric health assessments.
- A primary care referral list of medical providers in the county to whom you will refer to services. The referral list must include pediatricians, family and/or general practice physicians, internal medicine physicians, vision and hearing providers, and dentists. All providers must agree to be on your referral list, therefore, you must submit their written agreement with your referral list. The list must be sufficient in number to allow recipients/parents a choice in the selection of a provider.
- Documentation to demonstrate that services will be offered to all children enrolled at an off-site location, not just Medicaid-eligible children. A copy of your fee schedule must be attached to your documentation and must include fees for non-Medicaid enrollees.
- Child abuse and confidentiality policies
- A signed Matrix of Responsibilities form between the off-site location authority (school superintendent, principal, day care director, etc.) and the screening provider. Only one screening provider will be approved per location.

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NOTE:

Only RNs that are employed by a FQHC, RHC, Health Department, Physicians office, and hospital may perform off-site EPSDT screenings.

- A signed agreement/letter from a local physician to serve as Medical Director. This physician may be a pediatrician, family practice physician, general practice physician, or an internal medicine physician. Proof of 6 pediatric focused credits (CME) from the previous year must be included with the signed agreement. EXCEPTION: A board-certified pediatrician should submit a copy of current certification only. **The medical director is responsible for resolving problems that the nurses encounter and rendering care for medical emergencies.**

- A monthly schedule shall be maintained designating the dates, times, and the local agency in which you will be offering the EPSDT services. The monthly schedule should be readily available and retained in either the local agency/medical facility (i.e., the facility that has been approved as an off-site EPSDT screening provider) or the recipient's medical record. Failure to maintain schedules one week in advance of Off-site EPSDT screenings may result in termination and loss of revenue.
- A document, listing members of the Peer Review Coalition of community members to serve in an advisory capacity. The committee must have the opportunity to participate in policy development and program administration of the provider's off-site program and to advise the director about health and medical service needs within the community. The committee must be comprised of parents, school personnel, public health personnel and local physicians within the local community. Members must be familiar with the medical needs of low-income population groups and with the resources available in the community.
- Information packet materials, including letters, forms, and examples of anticipatory guidance information sheets to be used. These materials must be prior approved by Medicaid.
- A copy of the waiver certificate and/or CLIA number, issued by the Division of Health Care Facility, Bureau of Health Provider Standards for the State of Alabama Department of Public Health.
- A list of all physical locations at which EPSDT screenings will be provided. A separate NPI will be assigned to each off-site location and will be distinct from any other NPI. A separate application and contract is required for each off-site location.

A.5.2 Space for Screenings

The room in which screenings are done may vary according to the availability of space. Space to perform the screening assessment must include a well-lighted private room in close proximity to hot and cold running water, a bathroom, and a nearby waiting area.

A.5.3 Parent/Guardian Consent and Follow-up

Children under 14 years of age must have written consent from their parent/guardian before participating in the screening program. Children age 14 and above may

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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 visits (screenings) until approval has been authorized in writing and Medicaid has enrolled the provider for off-site screenings.

A.6 Vaccines for Children

In an effort to increase the immunization levels of Alabama's children by two years of age, the Alabama Department of Public Health and the Alabama Medicaid Agency implemented the Vaccines for Children (VFC) Program on October 1, 1994,

This nationally sponsored program offers free vaccines to family and general practitioners, pediatricians, hospital nurseries, emergency rooms, and other qualified providers for children aged 18 years and under who are Medicaid enrolled and eligible, have no health insurance, or are American Indian or Alaskan Native. Free vaccines are also available to children who do not have health insurance for immunizations (“underinsured”), if they obtain those vaccines from a Federally Qualified Health Center or Rural Health Clinic.

Participation in Medicaid is not required for VFC enrollment; however, over 400,000 of Alabama’s children are Medicaid enrolled.

A.6.1 Fees

Medicaid has taken the past vaccine and administration fee costs and calculated an equivalent reimbursement fee of $8.00 per dose. When multiple doses are given during the same visit, Medicaid will reimburse for each dose. When doses are given in conjunction with an EPSDT screening or physician visits, an administration fee of $8.00 per injection will also be paid for recipients 18 years of age and younger. The statewide fee-for-service will be paid for recipients 19 years of age and older. Providers are encouraged to utilize licensed available combination vaccines when indicated rather than the individual components of the vaccine.

Providers should use the immunization(s) procedure code designated by the VFC Program when billing for the administration of an immunization. Please refer to section A.6.3 for the list of designated VFC procedure codes.

Medicaid VFC providers may give VFC vaccines to children who are Medicaid enrolled, uninsured, American Indian, or Alaskan Native. If a VFC vaccine is given to any of the above patients, with the exception of Medicaid enrolled, an administration fee not to exceed $19.79 for each vaccine administered may be charged. Underinsured patients must go to an FQHC or RHC, to receive VFC vaccines. . No VFC-eligible patient should be denied immunizations because of an inability to pay the administration fee.

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Physicians and health departments are not required to file recipient health insurance prior to filing Medicaid for preventive pediatric services, including administration fees for VFC. Exceptions to this rule require that all providers must file with a recipient's health plan when the plan is an HMO or other managed care plan. In addition, FQHCs and RHCs are required to file other insurance prior to filing Medicaid as are any providers receiving a lump sum payment for bundled services or a capitation payment from Medicaid.

A.6.2 Enrollment

The Department of Public Health is the lead agency in administering the VFC Program. Enrollment and vaccine order forms are available through the Immunization Division. Questions regarding enrollment should be directed to the VFC Coordinator at (800) 469-4599.

Participation in Medicaid is not required for VFC enrollment. Participation in the VFC Program is not required for Medicaid enrollment.

A.6.3 Vaccines for Children Billing Instructions

Providers must use an appropriate CPT code on a CMS-1500 claim form or UB-04 claim form in order to receive reimbursement for the administration of each immunization given from VFC stock.

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 codes must be used when billing Medicaid for immunizations for any recipient under age 19:

CPT Procedure Code	***Procedure Description***	***Lay Term Description***	***Brand Name Example(s)***
90380	RSV MAB IM 0.5 ML	RSV Monoclonal Antibody	Beyfortus
90381	RSV MAB IM 1 ML	RSV Monoclonal Antibody	Beyfortus
90587	DENGUE VACC QUAD 3 DOSE SUBQ	Dengue vaccine	Dengvaxia
90611	SMALLPOX&MONKEYPOX VAC 0.5ML	Smallpox and Monkeypox vaccine	
90619	MENACWY-TT VACCINE IM	Meningococcal conjugate vaccine	MenQuafi
90620	MENB-4C VACC 2	Menengococcal B vaccine	Bexsero

Added: 90611 SMALLPOX…Monkeypox vaccine

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CPT Procedure Code	*Procedure Description*	*Lay Term Description*	*Brand Name Example(s)*
	DOSE IM		
90621	MENB-FHBP VACC 2/3 DOSE IM	Meningococcal B vaccine	Trumenba
90633	HEPA VACC PED/ADOL 2 DOSE IM	Hepatitis A vaccine, Pediatric (1yo – 18yo)	
90636	HEP A/HEP B VACC ADULT IM	Hepatitis A and B vaccine, Adult (18yo ONLY)	
90647	HIB PRP-OMP VACC 3 DOSE IM	Hemophilus influenza type B vaccine (0yo – 18yo)	Pedvax
90648	HIB PRP-T VACCINE 4 DOSE IM	Hemophilus influenza type B vaccine (0yo – 18yo)	ActHIB Hibirix
90649	4VHPV VACCINE 3 DOSE IM	Human papilloma virus (HPV) vaccine, quadrivalent (9yo – 18yo)	Gardasil
90650	2VHPV VACCINE 3 DOSE IM	Human papilloma virus (HPV) vaccine, bivalent (9yo – 18yo)	Cervarix
90651	9VHPV VACCINE 2/3 DOSE IM	Human papilloma virus (HPV) vaccine, nonavalent	
90658	IIV3 VACCINE SPLT 0.5 ML IM	Influenza virus vaccine (3yo – 18yo)	
90670	PCV13 VACCINE IM	Pneumococcal 13-valent conjugate vaccine (0yo – 5yo: no diagnosis restrictions)	Prevnar-13
90670	PCV13 VACCINE IM	Pneumococcal 13-valent conjugate vaccine 6yo – 18yo: who are at high risk for invasive pneumococcal disease due to: • Anatomic or functional asplenia (ie: sickle cell disease or other hemoglobinopathies), congenital or acquired asplenia, or splenic dysfunction • Cerebrospinal fluid (CSF) leaks	Prevnar-13

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CPT Procedure Code	*Procedure Description*	*Lay Term Description*	*Brand Name Example(s)*
		• Chronic renal failure or nephrotic syndrome • Cochlear implant • Congenital immunodeficiency • Diseases associated with treatment of immunosuppressive drugs/radiation therapy: including Hodgkin disease, leukemia, lymphomas, malignant neoplasm, or solid organ transplant • HIV infection	
90671	PCV15 VACCINE IM	Pneumococcal 15-valent conjugate vaccine	Vaxneuvance
90672	LAIV4 VACCINE INTRANASAL	Influenza virus vaccine, quadrivalent; for intranasal use (2yo – 18yo)	FluMist
90674	CCIIV4 VAC NO PRSV 0.5 ML IM	Influenza virus vaccine, quadrivalent; for intramuscular use (6mo – 18yo)	Flucelvax
90677	PCV20 VACCINE IM	Pneumococcal 20-valent conjugate vaccine	Prevnar-20
90678	RSV VACC PREF BIVALENT IM	Respiratory Syncytial Virus (RSV) vaccine	Abrysvo
90680	RV5 VACC 3 DOSE LIVE ORAL	Rotavirus vaccine, pentavalent (0yo – 1yo)	
90681	RV1 VACC 2 DOSE LIVE ORAL	Rotavirus vaccine (0yo – 1yo)	Rotarix
90682	RIV4 VACC RECOMBINANT DNA IM	Influenza virus vaccine, quadrivalent	
90685	IIV4 VACC NO PRSV 0.25 ML IM	Influenza virus vaccine, quadrivalent; for intramuscular use (~6mo – 2yo)	Fluzone Afluria
90686	IIV4 VACC NO PRSV 0.5 ML IM	Influenza virus vaccine, quadrivalent; for	Fluarix Flulaval

Added: 90678 RSV VACC…(RSV) vaccine Abrysyo

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CPT Procedure Code	*Procedure Description*	*Lay Term Description*	*Brand Name Example(s)*
		intramuscular use	Fluzone Afluria
90687	IIV4 VACCINE SPLT 0.25 ML IM	Influenza virus vaccine, quadrivalent; for intramuscular use (~6mo – 2yo)	Fluzone Afluria
90688	IIV4 VACCINE SPLT 0.5 ML IM	Influenza virus vaccine, quadrivalent; for intramuscular use	Fluzone Afluria
90696	DTAP-IPV VACCINE 4-6 YRS IM	Diphtheria, tetanus, acellular pertussis, and polio vaccine (4yo – 6yo)	Kinrix
90697	DTAP-IPV-HIB-HEPB VACCINE IM	Diphtheria, tetanus, acellular pertussis, polio, haemophilus influenzae type B, and hepatitis B vaccine	Vaxelis
90698	DTAP-IPV/HIB VACCINE IM	Diphtheria, tetanus, acellular pertussis, polio, and haemophilus influenzae type B vaccine (0yo – 4yo)	Pentacel
90700	DTAP VACCINE < 7 YRS IM	Diphtheria, tetanus, and acellular pertussis vaccine (0yo – 6yo)	
90702	DT VACCINE UNDER 7 YRS IM	Diphtheria and tetanus vaccine (0yo – 7yo)	
90707	MMR VACCINE SC	Measles, mumps, and rubella vaccine (1yo – 18yo)	
90710	MMRV VACCINE SC	Measles, mumps, rubella, and varicella vaccine (1yo – 12yo)	
90713	POLIOVIRUS IPV SC/IM	Polio virus vaccine	
90714	TD VACC NO PRESV 7 YRS+ IM	Diphtheria and tetanus vaccine (7yo – 18yo)	
90715	TDAP VACCINE 7 YRS/> IM	Diphtheria, tetanus, and acellular pertussis vaccine (7yo – 18yo)	
90716	VAR VACCINE LIVE SUBQ	Varicella vaccine (1yo – 18yo)	

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CPT Procedure Code	*Procedure Description*	*Lay Term Description*	*Brand Name Example(s)*
90723	DTAP-HEP B-IPV VACCINE IM	Diphtheria, tetanus, acellular pertussis, hepatitis B, and polio vaccine (0yo – 18yo)	Pediarix
90732	PPSV23 VACC 2 YRS+ SUBQ/IM	Pneumococcal vaccine, polyvalent (2yo – 18yo)	Pneumovax 23
90734	MENACWYD/MEN ACWYCRM VACC IM	Meningococcal vaccine, serogroups A, C, W, Y, diphtheria toxoid carrier vaccine	
90744	HEPB VACC 3 DOSE PED/ADOL IM	Hepatitis B vaccine	
90756	CCIIV4 VACC ABX FREE IM	Influenza virus vaccine, quadrivalent	
91304	SARSCOV2 VAC 5MCG/0.5ML IM	COVID-19 vaccine	
91318	SARSCOV2 VAC 3MCG TRS-SUC IM	COVID-19 vaccine	
91319	SARSCV2 VAC 10MCG TRS-SUC IM	COVID-19 vaccine	
91320	SARSCV2 VAC 30MCG TRS-SUC IM	COVID-19 vaccine	
91321	SARSCOV2 VAC 25 MCG/.25ML IM	COVID-19 vaccine	
91322	SARSCOV2 VAC 50 MCG/0.5ML IM	COVID-19 vaccine	

Added: 91304 SARSCOV2 VAC…COVID-19 vaccine

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A.6.4 ImmPRINT Immunization Provider Registry

The Alabama Department of Public Health has established a statewide lifespan immunization registry. Effective September 1, 2018, all VFC providers are required to submit all VFC vaccines administered for accountability. Please visit their website at https://siis.state.al.us/ImmPrint/login/login.aspx for more information.

A.6.5 Recommended Immunization Schedule

You may access the recommended immunization schedule at https://www.cdc.gov/vaccines/schedules/.

The schedule indicates the recommended ages for routine administration of currently licensed childhood vaccines. Combination vaccines may be used whenever any components of the combination are indicated and its other components are not contraindicated. Providers should consult the manufacturers' package inserts for detailed recommendations.

A.6.6 Synagis

The drug Synagis must be prior authorized through Kepro at 1-800-748-0130. The new form for prior authorization is available on our website at www.medicaid.alabama.gov under Programs: Pharmacy Services: Pharmacy Forms and Criteria: Form 369 and Form 351 Instructions. The appropriate administration fee may be billed in addition to Synagis.

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A.7 Required Screening Protocols

The following tables list screening protocols for infants, children, and adolescents by recipient age.

	Infancy						Early Childhood				
Age	**1 Mo**	**2 Mo**	**4 Mo**	**6 Mo**	**9 Mo**	**12 Mo**	**15 Mo**	**18 Mo**	**24 Mo**	**3 Yr**	**4 Yr**
Medical Screening[1]	X	X	X	X	X	X	X	X	X	X	X
Initial/Interval History	X	X	X	X	X	X	X	X	X	X	X
Measurements											
Height and Weight	X	X	X	X	X	X	X	X	X	X	X
Head Circumference	X	X	X	X	X	X	X	X	X		
Body-mass index (BMI)									X	X	X
Blood Pressure/Pulse	S	S	S	S	S	S	S	S	S	X	X
Developmental Assessment	X	X	X	X	X	X	X	X	X	X	X
Physical Exam/Assessment [2]	X	X	X	X	X	X	X	X	X	X	X
Procedures											
Immunization[3]	X	X	X	X	X	X	X	X	X	X	X
Newborn Screening[4]	X+	X+	X+	X+	X+	X+					
Anemia Screening[5]			S		X	X+	S	S	S	S	S
Urine screening	Effective 10/01/2008, urine screens should be performed only when clinically indicated.										
Lead Screening[6]				S	X	X+		S	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
Health Education[7]	X	X	X	X	X	X	X	X	X	X	X
Vision Screening[8]	S/X	S/X	S/X	S/X	S/X	S/X	S/X	S/X	S/X	O/X	O/X
Hearing Screening[9]	S/X	S/X	S/X	S/X	S/X	S/X	S/X	S/X	S/X	S/X	S/X
Dental Screening[10]	S/X	S/X	S/X	S/X	S/X	S/X	S/X	S/X	S/X	S	S
TB Skin Test (TST)	TST should be performed after completing a risk assessment. Refer to A.3.6 for more detailed information.										

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	Middle Childhood					
Age	**5 Yr**	**6 Yr**	**7 Yr**	**8 Yr**	**9 Yr**	**10 Yr**
Medical Screening[1]	X	X	X	X	X	X
Initial/Interval History	X	X	X	X	X	X
Measurements						
Height and Weight	X	X	X	X	X	X
Head Circumference						
Body-mass index (BMI)	X	X	X	X	X	X
Blood Pressure/Pulse	X	X	X	X	X	X
Developmental Assessment	X	X	X	X	X	X
Physical Exam/Assessment [2]	X	X	X	X	X	X
Procedures						
Immunization[3]	X	X	X	X	X	X
Newborn Screening[4]						
Anemia Screening[5]	S	S	S	S	S	S
Urine screening	Effective 10/01/2008, urine screens should be performed only when clinically indicated.					
Lead Screening[6]	X+	X+				
Nutritional Assessment	S/X	S/X	S/X	S/X	S/X	S/X
Health Education[7]	X	X	X	X	X	X
Vision Screening[8]	O/X	O/X	O/X	O/X	O/X	O/X
Hearing Screening[9]	O/X	O/X	O/X	O/X	O/X	O/X
Dental Screening[10]	S	S	S	S	S	S
TB Skin Test (TST)	TST should be performed after completing a risk assessment. Refer to A.3.6 for more detailed information.					

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	Adolescent									
Age	**11 Yr**	**12 Yr**	**13 Yr**	**14 Yr**	**15 Yr**	**16 Yr**	**17 Yr**	**18 Yr**	**19 Yr**	**20 Yr**
Medical Screening[1]	X	X	X	X	X	X	X	X	X	X
Initial/Interval History	X	X	X	X	X	X	X	X	X	X
Measurements										
Height and Weight	X	X	X	X	X	X	X	X	X	X
Head Circumference										
Body-mass index (BMI)	X	X	X	X	X	X	X	X	X	X
Blood Pressure/Pulse	X	X	X	X	X	X	X	X	X	X
Developmental Assessment	X	X	X	X	X	X	X	X	X	X
Physical Exam/Assessment [2]	X	X	X	X	X	X	X	X	X	X
Procedures										
Immunization[3]	X	X	X	X	X	X	X	X	X	X
Newborn Screening[4]										
Anemia Screening[5]	S	S	S	S	S	S	S	S	S	S
Urine screening	Effective 10/01/2008, urine screens should be performed only when clinically indicated.									
Lead Screening[6]										
Nutritional Assessment	S/X	S/X	S/X	S/X	S/X	S/X	S/X	S/X	S/X	S/X
Health Education[7]	X	X	X	X	X	X	X	X	X	X
Vision Screening[8]	O/X	O/X	O/X	O/X	O/X	O/X	O/X	O/X	O/X	O/X
Hearing Screening[9]	O/X	O/X	O/X	O/X	O/X	O/X	O/X	O/X	O/X	O/X
Dental Screening[10]	S	S	S	S	S	S	S	S	S	S
TB Skin Test (TST)	TST should be performed after completing a risk assessment. Refer to A.3.6 for more detailed information.									

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Key:

X	Required at the visit for this age
X+	Perform blood level if unknown
S	Subjective assessment by history and/or observation with appropriate action to follow
O	Objective by standard testing methods

Footnotes:

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	Every visit should allow for the opportunity to update a child's immunization status.
4	PCP should verify initial newborn screening results collected by the birthing facility. If unable to verify initial results collect a bloodspot specimen and mark the filter form “First Test.” The BCL will accept specimens up to 12 months of age. A second newborn screening specimen is recommended at 2-6 weeks of age (4 weeks optimal) on all full-term infants with a normal first test screen. If the first test specimen was collected after two weeks of age, a second test is not recommended.
5	Hematocrit and/or hemoglobin values must be determined at a medical screening by 9 months of age. Providers have the option of obtaining the lead and Hct or Hgb at nine or twelve months of age. Hematocrit or hemoglobin must also be determined between 11-20 years of age. Any other time must be deemed medically necessary based on physical examination and nutritional assessment.
6	All children are considered at risk and must be screened for lead poisoning. A blood lead test is required at 12 and 24 months of age. Providers have the option of obtaining the lead and Hct/Hgb at 9 or 12 months of age.
	X indicates a lead screening is required. **X+** indicates a lead screening test is required for any Medicaid-eligible child 36 to 72 months of age who has not previously been screened for lead.
7	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.
8	Vision screenings must be performed on children from birth through age two by observation (subjective) and history. Objective testing begins at age three and should be documented in objective measurements.
9	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.
10	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.

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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 Gainwell. It contains the following sections:

- General Information
- Provider Electronic Solutions
- Vendor Software
- Alabama Medicaid Interactive Website

Technical support is available through the Gainwell Electronic Claims Submission Help Desk.

(800) 456-1242 (Nationwide Toll Free)
(334) 215-0111

B.1 General Information

All claims which do not require attachments or an Administrative Review override by Medicaid must be submitted electronically. Electronic Claim Submission (ECS) offers many benefits to all participants in the claims submission process. ECS is the most efficient and effective means of processing claims, ensuring swift adjudication and payment to providers.

Electronic claim submission reduces claims processing time from start to finish. Rather than mailing paper claims, providers use the Alabama Medicaid Interactive website to submit claims to a central location.

With ECS, electronic claims avoid the sorting and keying process. The claim data is immediately available to the system. However, it is not only at the start of the claims cycle that electronic submission can save providers time.

Providers who submit claims electronically can check their claims to ensure that the data has passed basic edits, or can determine claim data that prevents the claim from paying. Providers can determine how much payment they will receive from each submission, in a fraction of the time it took when submitting claims on paper.

ECS assists providers in receiving quick payment and reduces claims processing time. Also, electronic claims submission provides an audit trail of claims that have failed preliminary edits. Providers may receive information regarding certain problems on submitted claims within minutes. This allows the provider the opportunity to the make necessary corrections and resubmit the claim before the next scheduled check writing date.

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To submit claims electronically, providers use software designed specifically for this purpose as well as the Alabama Medicaid Interactive web site. Providers may use software created by Gainwell, called Provider Electronic Solutions software, or software developed by outside vendors. The following three sections provide general information about each electronic option.

B.2 Provider Electronic Solutions

Provider Electronic Solutions software is data entry software used to verify eligibility and transmit claims in the proper format to the web so that they may be processed by the system.

Provider Electronic Solutions software is available free of charge to any provider. Gainwell will mail the software to the provider at no cost, or the provider may download the software from the Internet.

http://medicaid.alabama.gov/content/7.0_Providers/7.8_PES_Software.aspx

Providers use the Provider Electronic Solutions software to submit the following batch transaction types:

- 270 Eligibility Request
- 276 Claim Status Request
- 278 Prior Authorization Request
- 837 Dental
- 837 Institutional Inpatient
- 837 Institutional Nursing Home
- 837 Institutional Outpatient
- 837 Professional
- NCPDP Pharmacy Eligibility
- NCPDP Pharmacy
- NCPDP Pharmacy Reversal

B.2.1 Verifying Eligibility

Providers have access to all available eligibility information on a recipient including but not limited to the following:

- Recipient name on file
- Full recipient number including the check digit (13th digit)
- Alabama Coordinated Health Network (ACHN)
- 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

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NOTE:

The Provider Electronic Solutions software offers the feature of verifying recipient's eye care benefit limits. Select the eligibility icon and enter the requested information in all of the fields. When inquiring about a recipient's eligibility for eye care services, be sure to check the current year and previous year. For example, to determine if a recipient has met the benefit limit allowed for eye exams services, the provider needs to check the current and previous year service usage by entering the appropriate service year.

Providers have access to the following information about their submissions.

- **Communication Log** - displays information about successful or non-successful communication during transaction submissions
- **View Batch Response** - allows the user to view the response files downloaded from the web. For example claim responses 277 may be viewed after the submission of a 276 – Claim Status.
- **Download Electronic Remittance Advice (ERA)** - allows the user to download the 835 - Electronic Remittance Advice (ERA). The 835 file should be viewed in a text editor as the Provider Electronic Solutions software cannot display the Electronic Remittance Advice file.

B.2.2 Using Report and List Features: Managing your Data

Providers use the Lists feature to store frequently submitted values. These values can then be reused in later claims submissions, shortening data entry time. Provider Electronic Solutions software stores lists of data about the following topics:

- Attending/Operating Provider
- Prescriber
- Provider
- Recipient
- UPIN
- Admission Type
- Carrier
- Condition Code
- Diagnosis ICD-9
- Diagnosis ICD-10
- Modifier
- NDC
- Occurrence
- Patient Status
- Place of Service
- Policy Holder
- Procedure HCPCS

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- Procedure ICD-9
- Procedure ICD-10
- Revenue
- Taxonomy
- Type of Bill

Providers can generate reports about these lists, as well as detail and summary reports about the claims they have submitted.

B.2.3 Archive and Connection Tools: Protecting your Data

Providers use the Get Upgrades option to upgrade their software from any downloaded update through the web. Options allow users to set up their modems, batch and interactive submitter IDs, carrier information (for example, phone number to dial), and to establish their retention settings (sets the number of files to keep before archiving).

The Archive tool allows users to create archives and restore archives. This feature is very useful for space conservation on the provider's computer system. The Database Recovery tool allows users to compact, repair, and unlock their databases. These tools are very useful in correcting database problems, allowing users to correct the problem without Gainwell sending new software.

B.2.4 Additional Information about Provider Electronic Solutions

Provider Electronic Solutions software does not interface with accounting systems or other databases. This would require claims data to be keyed twice, once when submitting the claim using Provider Electronic Solutions software and again into the provider's database.

However, this software is perfect for providers who do not submit a large number of Medicaid claims, and for providers who want to save the vendor fee.

Provider Electronic Solutions software comes with full installation instructions, a user's guide, and full technical support.

For more information on obtaining Provider Electronic Solutions software, contact the Gainwell Electronic Claims Submission Help Desk.

(800) 456-1242 (Nationwide Toll Free)
(334) 215-0111

B.3 Vendor Software

Providers may prefer to submit claims using vendor software. Providers are recommended to contact Gainwell to determine if their vendor's software is approved for claims submission.

B.4 Alabama Medicaid Interactive Web Site

The Interactive Services web use of online user friendly forms, allows providers to inquire about recipient eligibility, claim status, prior authorization

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requests and household inquiries. A provider will also able to enter and submit claims, including online voids and adjustments.

The website is available free of charge to any provider. This site is available 24-hours a day, seven days a week, excluding time for scheduled maintenance.

The Alabama Medicaid Interactive web site address is https://www.medicaid.alabamaservices.org/ALPortal .For additional information regarding the features or sign-up procedures, refer to the Alabama Medicaid Interactive Web Site User Manual, found on the site's AL Links page under the Information menu.

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C 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 8 through 55 years of age and males of any age who may be sexually active and meet the criteria for Medicaid eligibility. Family planning services **do not require a referral** for recipients in Medicaid's Managed Care programs.

Reimbursement will be made only for eligible Medicaid recipients. Eligibility should be verified **prior to rendering** services to **ANY** Medicaid recipient.

Maternity Care eligible Medicaid women are covered for family planning services through the last day of the 12th postpartum month.

Plan First

The Plan First Program is an 1115 Demonstration Waiver approved by the Centers for Medicare and Medicaid Services that extends family planning coverage for eligible women ages 19 through 55 and men age 21 or older, for vasectomy/vasectomy related services and care coordination. 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 or verbal consent prior to receiving family planning services. For any face-to-face encounter a written consent is required. For any telephonic encounter a verbal consent is required. **A recipient consent for services must be obtained at each Family Planning visit. A sign-in logbook may be used after the initial consent form has been signed.**

Age of Consent

Family planning services are available to:

- Females, any age, after onset of menses. If age 14 or over, no parental or other consent is required.
- Males, any age. If age 14 or over, no parental or other consent is required.
- If a child is under the age of 14, whether they are sexually active or not, parental consent is required.

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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

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 recipient,
K = provide Knowledge
L = Listen for feedback,
E = Elaborate or reeducate as needed.

+3 = Summarize the teaching session into three essential points.

At all points during the counseling and education process, the recipient 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 recipient. Priority Two includes those topics that can be presented to the recipient 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 recipient need/desire further clarification.

At all times, the PT+3 method of teaching/counseling should be used so that time is targeted toward individual recipient need.

Priority One Topics:

1. Recipient 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 or testicular inspection and self-awareness

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

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Family Planning Protocols – Educational

		INIT	AN	Per	EXT/C	Home
Counseling Using PT + 3 Teaching Method						
Priority One	*Recipient expressed needs or problems*	X	X	X	X	X
	Contraceptives: **** Listing of the various options* ****How to use* **** Side effect management*	X	X	CI	X	X
	Prevention of STDs including HIV	X	X	CI	X	CI
	Breast or testicular inspection and self-awareness	X	X	X	X	X
Priority Two	*Explanation of any screening or lab testing done*	X	X	X	X	X
	Services offered	X	X			
	Telephone number of office or instructions regarding the accessing of emergency care	X	X	X	X	X
	Folic Acid	X	X			
Priority Three	*Need for Mammogram*	X	X			
Optional	Anatomy and physiology	CI	CI	CI	CI	CI

***Topic priority explanations: Priority One** includes those topics that MUST be discussed with the recipient. All recipient 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 recipient. At all times, if the recipient wants to discuss a topic, the opportunity should be provided.

NOTE:

Per ACOG Practice Bulletin Number 179 of July 2017 (*reaffirmed 2021*);
breast self-examination is no longer recommended in average-risk women because there is a risk of harm from false-positive test results and a lack of evidence of benefit.
Unlike breast self-examination, breast self-awareness does not include a recommendation for women to examine their breasts in a systematic way or on a routine basis. Rather, it means that a woman should be attuned to noticing a change or potential problem with her breasts.
Although breast self-examination is no longer recommended, evidence on the frequency of self-detection of breast cancer provides a strong rationale for breast self-awareness in the detection of breast cancer.
https://www.acog.org/clinical/clinical-guidance/practice-advisory/articles/2018/08/cervical-cancer-screening-update

https://www.acog.org/clinical/clinical-guidance/practice-bulletin/articles/2017/07/breast-cancer-risk-assessment-and-screening-in-average-risk-women

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The following services are covered services when provided by Family Planning providers.

Initial Visit (99205-FP)

The initial visit is the first time a Plan First or Family Planning 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 recipient's need and on protocol requirements.

Billable laboratory services **for the initial visit may include:**

- Hemoglobin or hematocrit,
- Urinalysis,
- Pap smear according to current, nationally recognized clinical guidelines,
- STD/HIV test, and
- Pregnancy testing.

Since a family planning visit may be the only medical encounter a female has, **performing the above laboratory tests is encouraged at the initial and annual visits.** Any laboratory procedure performed within the past 30 days with available results need not be repeated.

Pregnancy testing is a covered service during any visit where clinical indication is present and evaluation is needed.

NOTE:

Pap smears, not technically related to any contraceptive method, may be provided accordingly to the current standard of care and schedule. Providers must have and follow a Pap smear protocol based on the guidelines of a nationally recognized organization, such as the American College of Obstetrics and Gynecology (ACOG), the American Cancer Society (ACS), or the U.S. Preventive Services Task Force (USPSTF). These guidelines can be accessed at the following links:

https://www.acog.org/clinical/clinical-guidance/practice-advisory/articles/2018/08/cervical-cancer-screening-update

https://www.cancer.org/cancer/cervical-cancer/detection-diagnosis-staging/cervical-cancer-screening-guidelines.html

https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/cervical-cancer-screening

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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 inspection
- 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 inspection for males.

Annual Visit (99214-FP)

The annual visit is the re-evaluation of an established Plan First or Family Planning recipient 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

  The **physical assessment** is another integral part of the annual family planning visit. The following services, at a minimum, **must** be provided during the annual 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.
- Issuance of supplies or prescription.

Billable laboratory services **for the annual visit may include:**

- Hemoglobin or hematocrit,
- Urinalysis,
- Pap smear, according to current, nationally recognized clinical guidelines,
- STD/HIV test, and

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- Pregnancy testing.

Periodic Revisit (99213-FP)

The periodic revisit is a follow-up evaluation of an established Plan First or Family Planning recipient 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 Z304 diagnosis code for ICD-10, "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 periodic revisit:

- Weight and blood pressure
- Interim history
- Symptom appraisal as needed
- Documentation of any treatment/counseling including administration/issuance of contraceptive supplies.

NOTE:
Family Planning visits are not payable after sterilization.

Home Visit (99347-FP)

The home visit is a brief evaluation by a medical professional in the home of an established recipient 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 postpartum period and usually occurs within 7-14 days after delivery. A home visit is not a covered service for recipients with Plan First eligibility and can only be provided as a family planning service by Medicaid eligible family planning providers to eligible recipients.**

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 recipient:
  - 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 recipient must give her signed consent for this visit.

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Extended Family Planning Counseling Visit (99212-FP)

The extended family planning counseling visit is a separate and distinct service consisting of a minimum of 10 face-to-face minutes of extended contraceptive counseling using the PT+3 teaching method. The extended family planning counseling visit is for postpartum women and 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. An extended family planning counseling is limited to once during the post-partum period and is not available for women who have undergone a sterilization procedure or Plan First eligible recipients on the Plan First Program. It is not a covered service for recipients with Plan First eligibility and can only be provided as a family planning service by Medicaid eligible family planning providers to eligible recipients**.**

The following services are required:

- Contraceptive counseling and education
- STD/HIV risk screening and counseling, and
- Issuance of contraceptive supplies.

NOTE:

In the event of a premature delivery or miscarriage, the EDC, "Expected Date of Confinement", must be documented on the claim form in block 19 in order to be reimbursed for procedure code 99212-FP.

All visits must be documented in the recipient's chart and reflective of the treatment and care provided.

STD/HIV Risk Screening and (Pre-HIV test) Counseling (99401, Diagnosis Code Z309 [ICD-10])

STD/HIV screening, counseling, and testing is necessary to identify possibly infected persons who will benefit from medical treatment and to support and encourage all persons to practice responsible sex. Recipients who contract an STD are at greater risk of contracting HIV. Those who are HIV positive and contract an 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/HIV risk counseling.

Basic requirements of STD/HIV screening and counseling are:

1. Determine degree of risk
2. Intervene with education and counseling
3. Test for STD/HIV as clinically indicated
4. Screen for risk at the initial and annual visit or as clinically indicated
5. Document using Form 189 (STD/HIV Risk Screening and Intervention Tool)

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Requirements Detailed:

- Determine degree of risk.
- Screen for STD/HIV risk using the screening tool provided. See Attachments for a reproducible copy.
- Intervene with education and counseling.
    a. Risk Level I - No risk factors identified. Minimal counseling required.
    b. Risk Level II - At Risk – Due to exposure to blood or blood products only. Limited counseling required.
    c. Risk Level III - One or more risk factors present: Prevention Counseling required using the PT+3 method.
- Test for STD/HIV as indicated by screening results and clinical symptoms.
- Document using the Form 189 (STD/HIV Risk Screening and Intervention Tool)
- 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/HIV testing should be done as clinically indicated.

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/HIV testing.

STD/HIV Post-Test Counseling (99402, Diagnosis Code Z309 [ICD-10])

Post-test counseling is performed to provide the recipient with test results. When STD testing results in a positive finding, the recipient 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. (Form 189- STD/HIV Risk Screening and Intervention Tool).

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NOTE:

Counseling is limited to two counseling services per recipient each calendar year and must be performed in conjunction with a family planning visit. This means Medicaid will pay for a total of two counseling services. The recipient can have two services of 99401; or two services of 99402 or one service of 99401 and one service of 99402 in the same calendar year. Once two counseling services (99401 or 99402) are paid for the recipient for the year, Medicaid will not pay for additional counseling services for that calendar year.

BMI Requirements

Family Planning providers that bill procedure codes 99201-99205, 99211-99215, and 99241-99245 must include a BMI diagnosis on the claim or the claim will be denied. In instances where a BMI cannot be determined (e.g., wheelchair bound recipients) an override request may be submitted after the claim has been filed and denied. See Chapter 40 for Override request procedures.

The table below provides a description of procedure codes and ICD-10 codes that require a percentile on the CMS 1500 claim form for **recipient's age 8-19 years**:

Procedure Code Description	ICD-10 Diagnosis Code Description for Ages 8-19
99201 Office/Outpatient Visit New 99202 Office/Outpatient Visit New 99203 Office/Outpatient Visit New 99204 Office/Outpatient Visit New 99205 Office/Outpatient Visit New 99211 Office/Outpatient Visit Est 99212 Office/Outpatient Visit Est 99213 Office/Outpatient Visit Est 99214 Office/Outpatient Visit Est 99215 Office/Outpatient Visit Est 99241 Office Consultation 99242 Office Consultation 99243 Office Consultation 99244 Office Consultation 99245 Office Consultation	Z6851 BMI Pediatric, Less Than 5th Percentile for Age Z6852 BMI Pediatric, 5th Percentile to Less Than 85% for Age Z6853 BMI Pediatric, 85% To Less Than 95th Percentile for Age Z6854 BMI Pediatric, Greater Than or Equal To 95% for Age

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The table below provides a description of procedure codes and ICD-10 codes that require a BMI on the CMS 1500 claim form for **recipients age 20 and older**:

Procedure Code Description	ICD-10 Diagnosis Code Description For Ages 20 and Older
99201 Office/Outpatient Visit New 99202 Office/Outpatient Visit New 99203 Office/Outpatient Visit New 99204 Office/Outpatient Visit New 99205 Office/Outpatient Visit New 99211 Office/Outpatient Visit Est 99212 Office/Outpatient Visit Est 99213 Office/Outpatient Visit Est 99214 Office/Outpatient Visit Est 99215 Office/Outpatient Visit Est 99241 Office Consultation 99242 Office Consultation 99243 Office Consultation 99244 Office Consultation 99245 Office Consultation	Z681 Body Mass Index (BMI) 19 Or Less, Adult Z6820 Body Mass Index (BMI) 20.0-20.9, Adult Z6821 Body Mass Index (BMI) 21.0-21.9, Adult Z6822 Body Mass Index (BMI) 22.0-22.9, Adult Z6823 Body Mass Index (BMI) 23.0-23.9, Adult Z6824 Body Mass Index (BMI) 24.0-24.9, Adult Z6825 Body Mass Index (BMI) 25.0-25.9, Adult Z6826 Body Mass Index (BMI) 26.0-26.9, Adult Z6827 Body Mass Index (BMI) 27.0-27.9, Adult Z6828 Body Mass Index (BMI) 28.0-28.9, Adult Z6829 Body Mass Index (BMI) 29.0-29.9, Adult Z6830 Body Mass Index (BMI) 30.0-30.9, Adult Z6831 Body Mass Index (BMI) 31.0-31.9, Adult Z6832 Body Mass Index (BMI) 32.0-32.9, Adult Z6833 Body Mass Index (BMI) 33.0-33.9, Adult Z6834 Body Mass Index (BMI) 34.0-34.9, Adult Z6835 Body Mass Index (BMI) 35.0-35.9, Adult Z6836 Body Mass Index (BMI) 36.0-36.9, Adult Z6837 Body Mass Index (BMI) 37.0-37.9, Adult Z6838 Body Mass Index (BMI) 38.0-38.9, Adult Z6839 Body Mass Index (BMI) 39.0-39.9, Adult Z6841 Body Mass Index (BMI) 40.0-44.9, Adult Z6842 Body Mass Index (BMI) 45.0-49.9, Adult Z6843 Body Mass Index (BMI) 50-59.9, Adult Z6844 Body Mass Index (BMI) 60.0-69.9, Adult Z6845 Body Mass Index (BMI) 70 or Greater, Adult

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C.2.2 Family Planning Protocols-Clinical

Visits	*INIT*	*AN*	*PER*	*EXT/C*	*HOME*
Consent for Services	*X*	*X*	*X*	*X*	*X*
History					
Family	X	X			X
Med/Surg/OB-GYN	X	X			X
Contraceptive	X	X			X
STD/HIV screening	X	X	CI	CI	CI
Interim		X	X		
Blood Pressure	X	X	X		X
Weight	X	X	X		X
Height	X	X			
Physical Exam					
Skin/General appearance	X	X	CI		
Eyes/ENT	X	X	CI		
Head/Neck/Thyroid	X	X	CI		
Nodes	X	X	CI		
Heart/Lungs	X	X	CI		
Breast/SBE	X	X	CI		
Abdomen	X	X	CI		
Extremities/Back	X	X	CI		
External genitalia	X	X	CI		
Glands	X	X	CI		
Vagina	X	X	CI		
Cervix	X	X	CI		
Uterus size/shape	X	X	CI		
Adnexa	X	X	CI		
Recto-vaginal	X	X	CI		
Rectum	X	X	CI		
Laboratory					
HGB or HCT	CI	CI	CI		
Urinalysis	CI	CI	CI		
Pap smear (according to current recommendations)	CI	CI	CI		
STD tests including HIV	CI	CI	CI		
Pregnancy testing	CI	CI	CI		

CI - As clinically indicated

X - Required

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C.2.3 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 implantable contraceptive capsules.
b. Pregnancy related services.

C.2.4 Family Planning Drugs

Medically approved pharmaceutical supplies and devices, such as oral contraceptive pills, contraceptive patches, intrauterine devices, diaphragms, injections and implants are covered if provided for family planning purposes.

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 **Federal 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 recipient into being” sterilized.

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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.

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In addition, the provider shall:

a. 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.
b. Provide information and instructions concerning the need for follow-up, particularly for male recipients.
c. 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.

C.3.3 Digital Submission of the Sterilization Consent Form and Supporting Documentation

Effective October 26, 2016, providers will be able to upload or fax their fillable Sterilization Consent Forms and supporting documentation for review and processing via the Forms menu of the Alabama Medicaid Interactive Web Portal. A new form will allow providers the ability to upload Consent Forms and supporting documents in PDF format or create a fax barcode cover sheet from the Web Portal. Providers may submit additional documentation via fax at a later time and have that documentation combined with original document through the use of the same barcode cover sheet.

The provider must submit a copy of the recipient's signed sterilization consent form and supporting documentation to Gainwell via Provider Web Portal upload or fax at: (334) 215-7416.

Refer to Chapter 5, Filing Claims, for instructions on the digital submission of the Sterilization Consent Form and supporting documentation.

IMPORTANT NOTE:

The electronic fillable Sterilization Consent form and supporting documentation will be accepted in paper format via mail or fax **until November 27, 2016** at the following address and fax number:

Gainwell

Attention: Medical Policy Unit/Consent Forms

P.O. Box 244032, Montgomery Alabama 36124-4032

Fax Number: (334) 215-7416

After that date, consent forms and supporting documentation submitted to Gainwell on paper will be returned to the provider.

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Electronic Fillable Version Sterilization Consent Form

An electronic fillable version of the Sterilization Consent Form is available on the Alabama Medicaid's website at the following link: http://www.medicaid.alabama.gov/documents/9.0_Resources/9.4_Forms_Library/9.4.3_Consent_Forms/9.4.3_Form_193_Consent_Sterilization_Fillable_9-26-16.pdf

The electronic fillable version must be printed to complete the signatures and dates. All signature and dates must be completed in black ink to ensure faxed copies are legible. Only electronic fillable Sterilization Consent Forms, signatures and dates completed in blank ink will be accepted by Gainwell. Handwritten Sterilization Consent Forms will not be accepted via fax.

Reference the Sterilization Consent Form Detailed Instructions Guide for additional information.

Details Regarding the Completion of the Sterilization Consent Form

Sterilization forms must be legible, complete and accurate. Gainwell will NOT pay any claims to ANY provider until a correctly completed appropriate form is on file at Gainwell.

All blanks on the consent form **must be** appropriately **completed** before Medicaid pays the provider for the sterilization procedure.

Consent forms submitted to Gainwell with missing and/or invalid information in non-correctable fields **(recipient's signature and date recipient signed, signature of the person obtaining consent and date person obtaining consent signed, and interpreter's signature and date interpreter signed, if an interpreter is used)** of the consent form will be denied by Gainwell and not returned to the provider. **Revisions to non-correctable fields are not accepted for any reason**. Before sending the consent form to Gainwell, it is imperative that the date of surgery be clarified by reviewing the operative note to remedy claim denials due to incorrect date of surgery.

NOTE:

When the claim for the sterilization procedure is submitted to Gainwell, the claim will suspend in the system for 35 days waiting for the approved consent form to be entered. The Saturday after the claim is keyed into the system, it will check to see if the consent form has been entered. It will check the system each Saturday, up to 35 days, for the approved consent form. After the 35th day, the claim will deny for no consent form on file. If the approved consent form is found in the system during the 35 days, it will process the claim on the Saturday it finds the form.

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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 may sign the consent form on the same day as the recipient or after the recipient signs the consent form and prior to the date of the procedure.
e. If no interpreter is used, this section of the form must be marked as “Not Applicable” (N/A). If the “Interpreter’s Statement” is signed and dated, please complete the “in_____ language” line also. The recipient and interpreter must sign and date the consent form on the same date.

f. Procedure recorded in the “Physician’s Statement”: It is necessary for the recipient (by signature) to give consent in understanding their rights relative to the sterilization. Both sections of the form should indicate the same type of procedure. However, it is not necessary that the wording of the procedure/manner in which the sterilization is performed be identical under both sections of the form. Example: “Bilateral tubal ligation” listed in the recipient’s section and “postpartum tubal ligation” listed under the physician’s section is acceptable.

NOTE:

The physician's statement must be signed by the physician who is performing the sterilization procedure. Rubber stamped signatures are not permissible in this field. The physician must date the certification on the same date he or she signs it.

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C.4 Plan First

Plan First operates under an 1115 Demonstration Waiver granted by the Centers for Medicare and Medicaid Services (CMS). The Plan First Program expands the provision of family planning services to women, ages 19 through 55, and men ages 21 or older, with income up to 141 percent of the federal poverty level (FPL), that are not otherwise eligible for Medicaid. Men are eligible to receive only vasectomy services and enhanced family planning counseling services (referred to as "care coordination" services) with respect to arrangement for and follow-up to receipt of vasectomy services under the demonstration.

Plan First enrollees are also eligible to receive tobacco cessation counseling and products. Under Plan First, eligible women qualify for most family planning services and supplies, including birth control pills, the Depo-Provera shot, vaginal ring, diaphragm and contraceptive patch, doctor/clinic visits (for family planning only), smoking cessation products and counseling, and tubal ligations. Eligible men qualify for doctor/clinic visits (for family planning only), vasectomies and post semen analysis. Plan First does not cover any other medical services, and individuals who have been previously sterilized are not eligible for participation in this program.

NOTE:

Pain medication prescribed after a tubal ligation **is not** covered for a Plan First recipient. Women who receive a sterilization procedure and complete all necessary follow-up procedures will be disenrolled from Plan First.

NOTE:

If for medical reasons, a **Plan First recipient** requires an **inpatient stay** for sterilization, **prior approval** must be requested by the physician and approved by Medicaid prior to performing the sterilization. Please contact Gainwell for prior approval of an inpatient stay.

NOTE:

Effective for dates of service October 1, 2012 selected smoking cessation products are covered for Medicaid recipients on the Plan First Program. Prior authorization will not be required for Plan First recipients. Refer to Appendix Q Tobacco Cessation for additional information.

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C.5 Eligible Individuals

Eligible individuals are females of childbearing age between 19 through 55 years of age and men age 21 or older, for vasectomies only, who meet the eligibility criteria described below. These individuals are identified on the Eligibility Master File with an aid category of 50.

As always, providers are responsible for verifying eligibility and coverage via Provider Electronic Solutions (PES) or Automated Voice Response System (AVRS) systems.

Eligible recipients fall into four categories; however, there is no difference in benefits. The income limit for each of these groups must not exceed 141% of the federal poverty level (FPL). A standard income disregard of 5% of the FPL is applied if the individual is not eligible for coverage due to excess income. The four groups are described below:

Group 1

Women 19 through 55 years of age who have Medicaid eligible children (poverty level), who become eligible for family planning without a separate eligibility determination. They must answer yes to the Plan First question on the application. Income is verified at initial application and re-verified at recertification of their children. Eligibility is redetermined every 12 months.

Group 2

Poverty level pregnant women 19 through 55, whose pregnancy ends while she is on Medicaid. The Plan First Waiver system automatically determines Plan First eligibility for every female Medicaid member entitled to Plan First after a pregnancy has ended. Women automatically certified for the Plan First program receive a computer generated award notice by mail. If the woman does not wish to participate in the program, she can notify the caseworker to be decertified. Women who answered “no” to the Plan First question on the application and women who do not meet the citizenship requirement do not receive automatic eligibility. Income is verified at initial application and re-verified at re-certification of their children. Income is verified at initial application and re-verified at recertification of their children. Eligibility is redetermined every 12 months.

Group 3

Other women age 19 through 55 who are not pregnant, postpartum or who are not applying for a child must apply using a simplified shortened application. A Modified Adjusted Gross Income (MAGI) determination will be completed using poverty level eligibility rules and standards. Recipient declaration of income will be accepted unless there is a discrepancy. The agency will process the information through data matches with state and federal agencies. If a discrepancy exists between the recipient’s declaration and the income reported through data matches, the recipient will be required to provide documentation and resolve the discrepancy. Eligibility is redetermined every 12 months.

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Group 4

Plan First men only age 21 and older, for vasectomies may complete a simplified shortened Plan First application (Form 357). An eligibility determination must be completed using poverty level eligibility rules and standards. Eligibility will only be for a 12-month period; therefore, retro-eligibility and renewals are not allowed. If the individual has completed the sterilization procedure but has not completed authorized follow-up treatments by the end of the 12-month period, a supervisory override will be allowed for the follow-up treatments. If the individual does not receive a vasectomy within the 12-month period of eligibility, then he will have to reapply for Medicaid eligibility.

NOTE:

Effective January 2014, Plan First women can check on their initial application whether they want to renew their eligibility automatically up to 5 years using income data from tax returns.

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C.6 Plan First Provider Enrollment

Participation in Plan First is open to any provider who wishes to be Medicaid enrolled and executes a Plan First agreement. Only those Plan First enrolled providers are able to service Plan First eligibles. Providers can be clinics, private physicians, nurse midwives, nurse practitioners, or physician assistants. Providers are bound by the requirements in the Appendix C of the Alabama Medicaid Provider Manual; The American College of Obstetrics and Gynecology guidelines and the approved 1115 Plan First Demonstration Waiver.

In addition to enrolling as a Medicaid provider through Gainwell, the provider must complete a Plan First agreement.

Clinics and clinic-based providers (Health Departments, FQHCs, and RHCs) are enrolled as one group. Individual providers within these groups are not required to individually enroll. Plan First recipients have the option of using any provider within these groups.

A provider who contracts with Alabama Medicaid as a Plan First provider is added to the Medicaid system with the National Provider Identifiers provided at the time application is made. Appropriate provider specialty codes are assigned to enable the provider to submit requests and receive reimbursements for Plan First related claims. A specialty of 700 is added to the provider file for those enrolling in Plan First. In order for claims to process for Plan First recipients, this specialty code must be present on the provider file.

Medicaid providers that perform only tubal ligations or vasectomies do not have to enroll as Plan First providers. This includes surgeons, anesthesiologists and outpatient surgical centers.

If you have further questions regarding this program please call the Plan First Program Manager. If you wish to enroll please call Gainwell. Recipients may call the Plan First hotline toll-free at 1 (888) 737-2083 for more information.

C.6.1 Network List

The Alabama Medicaid Agency maintains a listing of all providers who have enrolled to provide services to Plan First eligibles. The list contains the provider's address and phone number and is sorted by the provider's county of practice. The list is made available to all Plan First care coordinators and staff of the Plan First toll free hotline, and will also be available to any other party who may be assisting individuals in locating a Plan First provider. The list is available online at the Alabama Medicaid web site (www.medicaid.alabama.gov) as well as in printed form.

Confidentiality

Providers agree that any information obtained through this program is confidential and will not be disclosed directly or indirectly except for purposes directly connected with the conduct of this program. The informed, written or verbal consent of the individual must be obtained for any disclosure.

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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.

C.7.1 Oral Contraceptives, Contraceptive Patch and Vaginal Ring

Effective 11/1/2009, women on Plan First have a new option of obtaining oral contraceptives, the contraceptive ring or the contraceptive patch at a Medicaid-enrolled community/outpatient pharmacy. This is in addition to the contraceptive products already available at the pharmacy such as Depo and diaphragms. In order to fill a prescription at a community/outpatient pharmacy, the Plan First recipient must have received the prescription from a private provider. A 30-day supply is the maximum that may be dispensed at one time.

NOTE:

Plan First recipients seeing providers at a Federally Qualified Health Center (FQHC) or the health department will continue to receive the oral contraceptives, contraceptive patch or vaginal ring from the FQHC or health department provider. A 12-month supply of contraceptives may be dispensed at one time. Recipients can also receive a Depo-Provera injection at a FQHC or the health department.

C.7.2 Long Acting Reversible Contraception

Effective for dates of service June 4, 2019, and thereafter, Alabama Medicaid will reimburse the cost of the long acting reversible contraceptive to the facility when provided in the inpatient hospital setting immediately after a delivery or up to the time of the inpatient discharge for postpartum women, or in an outpatient setting immediately after discharge from the inpatient hospital for postpartum women. The insertion of the device/drug implant will be billable to Medicaid by both the physician and hospital for reimbursement.

Refer to Chapter 19 Hospital for additional information.

NOTE:

Effective January 1, 2015, Plan First providers will receive reimbursement for the surgical removal of migrated or embedded IUDs in an office setting or outpatient hospital setting.

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C.7.3 Vasectomies

Effective for dates of service August 1, 2015, and thereafter, Medicaid began coverage of vasectomies under the Plan First Program for Plan First males recipients age 21 or older. Coverage includes one initial and two periodic visits, vasectomy in an office or outpatient hospital setting and semen analysis. All men receiving a vasectomy are required to have a completed Alabama Medicaid sterilization Consent Form (Form 193) prior to surgery. The Sterilization Consent Form must be completed in accordance with the guidelines listed below in section C.12.

Initial Visit for Plan First Male Receiving a Vasectomy (99205-FP)

The initial visit is the first time a Plan First male recipient receives family planning services. An initial visit is limited to one per provider per recipient per lifetime and can only be billed by the provider performing the vasectomy.

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 recipient's need and on protocol requirements.

Billable laboratory services for the initial visit may include:

- Hemoglobin or hematocrit,
- Urinalysis,
- STD/HIV test, and

Since a family planning visit may be the only medical encounter a Plan First male has, **performing the above laboratory tests is encouraged at the initial visit.**

The **physical assessment** is an integral part of the initial family planning visit for the Plan First male. The following services shall 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
- Examination of extremities for edema and varicosity
- Testicular, genital, and rectal examination for males.

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Periodic Revisit for the Plan First Male Receiving a Vasectomy (99213-FP)

The periodic revisit is for a follow-up evaluation and semen analysis post vasectomy procedure for the Plan First male. Two periodic visits are allowed post vasectomy procedure for the eligible Plan First male recipient.

The following services, at a minimum, shall be provided during the periodic revisit:

- Weight and blood pressure
- Interim history
- Symptom appraisal as needed
- Documentation of any treatment/counseling including administration/issuance of contraceptive supplies.

Providers must use appropriate CPT, ICD Diagnosis Codes, and Place of Service Codes to bill for services provided.

The following CPT codes are applicable:

- **55250** Vasectomy- unilateral or bilateral, including postoperative semen examination(s)
- **00921** Anesthesia for vasectomy, unilateral or bilateral
- **89300** Semen analysis; presence and/or motility of sperm
- **99205-FP** Initial visit
- **99213-FP** Periodic visit

This procedure is only covered in an office or outpatient hospital setting, the place of service must be indicated on the CMS 1500 claim form in order to be reimbursed by Medicaid.

Place of Service Codes:

- **11** Office visit
- **22** Outpatient hospital setting

The following diagnosis codes must be billed in conjunction with the above CPT codes on the claim form (UB-04 or CMS-1500) in order to be reimbursed by Medicaid.

ICD-10 Diagnosis Code:

- **Z30018** Encounter for initial prescription of other contraceptives
- **Z302** Encounter for sterilization
- **Z308** Encounter for other contraceptive management

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C.7.4 Care Coordination

Care coordination services for females are designed to provide special assistance to those women who are at high risk or low 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.

Care coordination services for males are designed for males enrolled in the Plan First program for vasectomy services. The service is designed to **overcome barriers males may encounter in** trying to receive the covered service. This may include, but is not limited to, establishing Medicaid eligibility **(assistance with completing the Form 357 (Lavender Application), the Joint Paper Application (Single Streamline Application) or the on-line application at insurealabama.org as applicable),** finding a provider to perform the surgery and to ensure compliance with follow-up appointments, **and coordinating medical and social resources as identified.**

Should care coordination services be needed, a referral can be made by calling the recipient's Alabama Coordinated Health Network (ACHN) and asking for a Plan First Care Coordinator. Refer to Chapter 40 of the Provider Billing Manual for contact information for each ACHN region.

As mentioned above, the goal of care coordination is to form a partnership with the recipient to address impediments to successful family planning. The bio-psychosocial model of care coordination is used to achieve this goal and includes:

- A psychosocial assessment and development of care plan for all recipients 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 recipients receive care coordination services in a timely manner. All Plan First recipients are eligible to receive an initial risk assessment to determine if and what type of care coordination services is needed.

C.7.5 Recipient 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 or verbal consent prior to receiving family planning services.**

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C.8 Cost Sharing (Co-payment)

Medicaid recipients and Plan First beneficiaries are exempt from co-payment requirements for family planning services.

There are to be no co-payments on prescription drugs/supplies that are designated as family planning.

Plan First Claims Information

Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

Claims for family planning services - See sections C.11, Completing the Claim form and C.11.2 and C.11.4 for diagnosis and procedure codes. Service requirements per visit are detailed in Section C.2.2, Family Planning Protocol - Clinical.

Non-enrolled Plan First providers who are billing for a tubal ligation or a tubal ligation with a family planning visit can file an electronic or paper claim to Gainwell in order to receive reimbursement. The approved Plan First tubal codes are 58600, 58615, 58670, and 58671. The Plan First family planning visit codes are 99205-FP (initial), 99214-FP (annual), or 99213-FP (periodic). In addition to these codes, the diagnosis code Z309 for ICD-10 must be used as well **as a secondary modifier of 56**.

Non-enrolled Plan First providers who are billing for a vasectomy or a vasectomy with a family planning visit can file an electronic or paper claim to Gainwell in order to receive reimbursement. The approved Plan First vasectomy code is 55250. The Plan First family planning visit codes are 99205-FP (initial) or 99213-FP (periodic). In addition to these codes, the diagnosis code Z309 for ICD-10 must be used as well **as a secondary modifier of 56**.

If the sterilization is **not** performed, the non-enrolled provider must use diagnosis code Z30.9 for ICD-10 and a secondary modifier of 56 with procedure code 99205-FP, 99214-FP or 99213-FP.

For information about Third Party Liability, please refer to Chapter 3, Section 3.3.7, Third Party Liability.

C.9 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 recipients,
- To assure that recipient 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.

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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 recipients who are assessed to be at high risk or low risk of an unintended pregnancy. The Care Coordinators will make and follow a plan to aid the high risk and low risk recipients 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 has implemented several monitoring functions as outlined below:

- Utilization reports from claims data to monitor trends and utilization
- Monitor Care Coordinator activity via summary reports
- Review Summary Reports, from UAB
- Coordinate complaints and grievances to acceptable resolution.
- Conduct recipient medical record reviews

C.10 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 completed for “medical” reasons also have family planning implications.

- Sterilization by hysterectomy is not a family planning covered service.
- Abortions are not covered as a family planning service. Refer to Chapter 28, Physician's Program, for details about abortions.
- Hospital charges incurred when a recipient enters the hospital for sterilization purposes, but then opts out of the procedure cannot be reimbursed as a family planning service.
- Removal of an IUD due to a uterine or pelvic infection is not considered a family planning service, and is not reimbursable as such.
- Colposcopy and biopsy of cervix/vagina performed to identify and treat medical conditions are not considered family planning services.
- Diagnostic or screening mammograms are not considered family planning services.
- Medical complications requiring treatment (for example, perforated bowel) caused by or following a family planning procedure are not a covered family planning service.
- Any procedure or service provided to a woman who is known to be pregnant is not considered a family planning service.
- Removal of contraceptive implants due to medical complications are not family planning services.

C.11 Completing the Claim Form

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To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

Providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information.

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When filing a claim on paper, a CMS-1500 claim form is required.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

C.11.1 Time Limit for Filing Claims

Medicaid requires all claims for family planning to be filed within one year of the date of service. Refer to Section 5.1.5, Filing Limits, for more information regarding timely filing limits and exceptions.

C.11.2 Diagnosis Codes and BMI Requirements

ICD-10 Diagnosis Codes

Z30011	Encounter for initial prescription of contraceptive pills
Z30013	Encounter for initial prescription of injectable contraceptive
Z30014	Encounter for initial prescription of intrauterine contraceptive device
Z30018	Encounter for initial prescription of other contraceptives
Z30019	Encounter for initial prescription of contraceptives, unspecified
Z3002	Counseling and instruction in natural family planning to avoid pregnancy
Z3009	Encounter for other general counseling and advice on contraception
Z302	Encounter for sterilization
Z3040	Encounter for surveillance of contraceptives, unspecified
Z3041	Encounter for surveillance of contraceptive pills
Z3042	Encounter for surveillance of injectable contraceptive
Z30430	Encounter for insertion of intrauterine contraceptive device
Z30431	Encounter for routine checking of intrauterine contraceptive device
Z30432	Encounter for removal of intrauterine contraceptive device
Z30433	Encounter for removal and reinsertion of intrauterine contraceptive device
Z3049	Encounter for surveillance of other contraceptives
Z308	Encounter for other contraceptive management
Z309	Encounter for contraceptive management, unspecified
Z3202	Encounter for pregnancy test, result negative
Z641	Problems related to multiparity

NOTE:

All claims filed for Plan First recipients must utilize one of the family planning diagnosis codes noted above. This includes claims filed for lab services.

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Diagnosis codes that are used and not listed above will cause the claim for a Plan First recipient to deny.

NOTE:

ICD-10 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.

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C.11.3 Family Planning Indicator References

Providers must complete the Family Planning Indicator, as applicable. "Y or "N" are the only valid indicators, when filing electronic claims.

C.11.4 Procedure Codes, Modifiers, and BMI Requirements

The (837) Professional and Institutional electronic claims and the paper claim have been modified to accept up to four Procedure Code Modifiers.

Collection of laboratory specimens may be billed only when sending specimens to another site for analysis if the other site is not owned, operated, or financially associated with the site in which the specimen was collected.

The collection fee may not be billed if the lab work is done at the same site where the specimen was collected or in a lab owned, operated, or financially associated with the site in which the specimen was collected.

Providers will not be paid for and should not submit claims for laboratory work done for them by independent laboratories or by hospital laboratories.

Providers may submit claims for laboratory work done by them in their own offices or own laboratory facilities. Providers who send specimens to independent laboratories for analysis may bill a collection fee. This fee shall not be paid to any provider who has not actually extracted the specimen from the recipient.

NOTE:

Providers should use procedure code 36415-90 for routine venipuncture collection, 36416-90 for collection of capillary blood specimen (e.g., finger, heel, ear stick) and Q0091-90 for collection of Pap smear specimen.

NOTE:

Family planning visits do not count against the recipient's office visits when the procedure codes listed below and the appropriate family planning indicator are used.

Code	Procedure Description
99402	STD/HIV Post-test Counseling (Must be billed in conjunction with a family planning visit) – Limited to two per recipient per calendar year. (Must use diagnosis code Z309 for ICD-10)
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. (Must use diagnosis code Z309 for ICD-10)
88305	Level IV Surgical Pathology, gross and microscopic examination
88304	Level III Surgical Pathology, gross and microscopic examination
88302	Surgical pathology, gross and microscopic examination
88300	Level I Surgical Pathology, gross examination only
89300	Semen analysis; presence and/or motility of sperm
88175	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; with screening by automated system and manual rescreening, under physician supervision.

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Code	Procedure Description
88174	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; screening by automated system, under physician supervision.
88167	Cytopathology, slides, cervical or vaginal
88166	Cytopathology, slides, computer assisted rescreening
88165	Cytopathology, slides, cervical or vaginal
88164	Cytopathology, slides, cervical or vaginal
88162	Cytopathology, any other source
88161	Cytopathology, any other source
88160	Cytopathology, smears, any other source
88155	Cytopathology, slides, cervical or vaginal
88154	Cytopathology, slides, computer assisted
88153	Cytopathology, slides, manual screening & rescreening under physician supervision (use in conjunction with 88142-88154, 88164-88167)
88152	Cytopathology, slides, cervical or vaginal
88150	Cytopathology, manual screening under physician supervision
88148	Cytopathology, screening by automated system with manual rescreening
88147	Cytopathology smears, screening by automated system under physician supervision
88143	Cytopathology, manual screening & rescreening under physician supervision
88142	Cytopathology, cervical or vaginal, automated thin layer preparation
88141	Cytopathology, cervical or vaginal; requiring interpretation by physician (use in conjunction with 88142-88154, 88164-88167)
88108	Cytopathology, concentration technique, smears and interpretation
87850	Neisseria gonorrhea
87801	Infectious agent detection by nucleic acid (DNA or RNA), multiple organisms; amplified probe(s) technique
87798	Infectious agent detection by nucleic acid (DNA or RNA), not otherwise specified; amplified probe technique, each organism. (Not billable by ADPH effective June 30, 2015.)
87797	Infectious agent detection by nucleic acid (DNA or RNA); not otherwise specified, direct probe technique
87661	Trichomonas vaginalis, amplified probe technique
87660	Trichomonas vaginalis, direct probe technique
87625	Human Papillomavirus (HPV), types 16 & 18 only
87624	Human Papillomavirus (HPV), high-risk types
87623	Human Papillomavirus (HPV), low-risk types
87592	Neisseria gonorrhea, quantification
87591	Neisseria gonorrhea, amplified probe technique. (Not billable by ADPH effective June 30, 2015.)
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

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Code	Procedure Description
87491	Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia Trachomatis. Amplified probe technique. (Not billable by ADPH effective June 30, 2015.)
87490	Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia Trachomatis. Direct probe technique.
87482	Candida species, quantification
87481	Candida species, amplified probe technique
87480	Candida species, direct probe technique
87389	Infectious Agent Antigen
87220	Tissue examination for fungi
87210	Smear, primary source, with interpretation, wet mount with simple stain, for bacteria, fungi, ova, and/or parasites
87209	Smear, primary source with interpretation; complex special stain (eg, trichrome, iron hemotoxylin) for ova and parasites
87207	Smear, primary source, with interpretation, special stain for inclusion bodies or intracellular parasites (e.g., malaria, kala azar, herpes)
87206	Smear, primary source, with interpretation, fluorescent and/or acid fast stain for bacteria, fungi, or cell types
87205	Smear, primary source, with interpretation; routine stain for bacteria, fungi, or cell types
87177	Smear, primary source, with interpretation, wet and dry mount for ova and parasites, concentration and identification
87164	Dark field examination, any source; includes specimen collection
87110	Culture, chlamydia
87081	Culture, bacterial, screening only, for single organisms
86780	Antibody; Treponema Pallidum
86703	HIV – 1&2
86702	Antibody HIV-2
86701	HIV – 1
86695	Herpes simples, type 1
86694	Herpes simplex, non-specific type test
86689	HTLV or HIV antibody
86593	Syphilis
86592	Syphilis
85032	Manual cell count (erythrocyte, leukocyte or platelet) each
85027	Blood count; RBC only
85025	Blood count; hemogram and platelet count, automated, and automated complete differential WBC count (CBC)
85018	Blood count; hemoglobin
85014	Blood count; other than spun hematocrit
85013	Blood count; spun microhematocrit
85009	Blood count; differential WBC count, buffy coat
85008	Blood count; manual blood smear examination without differential parameters
85007	Blood count; manual differential WBC count (includes RBC morphology and platelet estimation)
84703	HCG qualitative
84702	HCG quantitative
81025	Urine pregnancy test
81020	Urinalysis; two or three glass test
81015	Urinalysis microscopic only
81007	Urinalysis; bacteriuria screen, by non-culture technique, commercial kit
81005	Urinalysis; qualitative or semiquantitative, except immunoassays
81003	Urinalysis; automated without microscopy
81002	Urinalysis; non-automated without microscopy
81001	Urinalysis; automated with microscopy

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Code	Procedure Description
81000	Urinalysis by dip stick or tablet reagent
76881	Contraceptive surveillance, unspecified of a missing Nexplanon
76830	Transvaginal Ultrasound Non-OB
76857	Ultrasound, Pelvic (Nonobstetric), real time with image documentation; limited or follow-up (EG, for follicles) **(This procedure is to be used for locating missing IUDs Only)**
74740	Hysterosalpingography, radiological supervision and interpretation
73060	X-ray of Humerus-Purpose Location of Nexplanon Capsules
58671	Tubal ligation by laparoscopic surgery
58670	Tubal ligation by laparoscopic surgery
58615	Tubal ligation by suprapubic approach
58611	Tubal ligation done in conjunction with a c-section (*Not applicable for Plan first)*
58605	Tubal ligation by abdominal approach (postpartum) (*Not applicable for Plan first)*
58600	Tubal ligation by abdominal incision
58565	Hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants (by Prior Approval only; **See note box below)
58562	Hysteroscopy, surgical; with removal of impacted foreign body
A4264	Intratubal occlusion device (by Prior Approval only; **See note box below)
58340	Catheterization and introduction of saline or contrast material for saline infusion sonohysterography (SIS) or hysterosalpingography
58301	IUD removal
58300	IUD insertion
57800-FP	Dilation of cervical canal, instrumental (separate procedure)
57410-FP	Pelvic examination under anesthesia (other than local)
57170	Diaphragm – fitting with instructions **only.** Does not include the device.
55250	Vasectomy –unilateral or bilateral, including postoperative semen examination(s)
11980	Subcutaneous hormone pellet implantation(implantation of estradiol and/or testosterone beneath the skin)
11976	Removal, implantable contraceptive capsule
11981-FP	Insertion, non-biodegradable drug delivery implant
11982-FP	Removal, non-biodegradable drug delivery implant
00921	Anesthesia for vasectomy, unilateral or bilateral
00952-FP	Anesthesia for hysteroscopy and/or hysterosalpingography procedures
00940-FP	Anesthesia for vaginal procedures (including biopsy of labia, vagina, cervix or endometrium); not otherwise specified
00851	Anesthesia Intraperitoneal procedures in lower abdomen including laparoscopy; tubal ligation/transection.
J1050-FP	Depo-Provera-no less than 104 mg and no more than 150 mg per injection once every 70 days
J7296	Kyleena IUD (Levonorgestrel-releasing intrauterine contraceptive system, 19.5mg limited to one every 5 years). Exceptions are in NOTE box below. **Effective January 1, 2018, providers should bill J7296 on the claim form for reimbursement**.
J7297	Liletta IUD (Levonorgestrel-releasing intrauterine contraceptive system, 52 mg) limited to one every 5 calendar years. Exceptions are in the NOTE box below

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Code	Procedure Description
J7298	Mirena IUD (Levonorgestrel-releasing intrauterine contraceptive system, 52 mg) limited to one every 5 calendar years. Exceptions are in the NOTE box below
J7301	Skyla IUD (limited to one every 3 years). Exceptions are in NOTE box below.
J7304-FP	Contraceptive Patch (For Health Department Billing Only) TPL exempt
J7304-SE	Contraceptive Patch (For FQHCs, PRHCs, IRHCs Billing only)
J7303-FP	Vaginal Ring (For Health Department billing only and is covered for Plan First)
*J3490	Kyleena IUD (limited to one every 5 years). Exceptions are in NOTE box below. * For dates of service April 01, 2017 through June 30, 2017 bill J3490. See Q9984 for dates of service July 01, 2017 through December 31, 2017.
99205-FP	Initial visit
99214-FP	Annual visit
99213-FP	Periodic visit
99347-FP	Home visit – Limited to one per post-partum period as a family planning covered service. (Not applicable for Plan First eligible recipients)
S4993-FP	Birth control pills (For Health Department billing only)
96372	Therapeutic, prophylactic or diagnostic injection (specify substance or drug); subcutaneous or intramuscular.
99212-FP	Extended contraceptive counseling visit (May be billed in conjunction with the postpartum visit – Limited to one service during the postpartum period as a family planning covered service. (Not applicable for Plan First eligible recipients.)
S4993-SE	Birth Control Pills (For FQHCs, PRHCs, IRHCs Billing only)
J7307	Etonogestrel (contraceptive) implant system, including implants and supplies also known as Nexplanon Effective 1/1/2008, J7307 replaces S0180
J7300	Mechanical (Paragard) IUD
Q0091	Collection of Pap smear specimen
Q0111	Wet mounts
Q9984	Kyleena IUD (limited to one every 5 years). Exceptions are in NOTE box below. Bill Q9984 for dates of service July 01, 2017 through December 31, 2017. See J7296 for dates of service January 1, 2018 and thereafter.
36415-90	Routine venipuncture for collection
36416-90	Collection of capillary blood specimen (eg, finger, heel, ear stick)

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Sterilizations

NOTE:

The Essure method of sterilization is restricted to Prior Approval and also requires a sterilization consent form. The limitations are as follows:
This procedure must be performed in an outpatient setting and the recipient must meet one of the following criteria:
Morbid obesity (BMI of 45 or greater); or
Abdominal mesh that mechanically interfaces with laparoscopic tubal ligation sterilization procedures; or
Permanent colostomy with documented adhesions; or
Multiple abdominal/pelvic surgeries with documented severe adhesions; or
Artificial heart valve requiring continuous anticoagulation; or
Other severe medical problems that would be a contraindication to laparoscopic tubal ligation procedures based on medical documentation submitted.
Effective January 1, 2010, Medical providers will use two procedures to bill for the Essure. A4264 will be used for reimbursement of the device and 58565 will be used for reimbursement of the procedure. The outpatient facility will only bill 58565 for the surgical procedure.

NOTE:

Once a sterilization claim is processed for a Plan First recipient, the Medicaid eligibility is ended. Therefore, a claim for the Essure related follow-up procedures (58340 and 74740) would deny due to no eligibility. The performing provider should submit the claims for procedures 58340 and 74740 for administrative review to:

Alabama Medicaid Agency
Plan First Program Manager
501 Dexter Avenue
Montgomery, AL 36103

The claims will be researched and a lump sum payment will be made to the provider if there is a paid claim on file for the Essure procedure.

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IUDs

NOTE:

Effective 1/1/2010, the Mirena IUD is restricted to 1 every 5 years. The recipient cannot have another Mirena IUD, but may receive a different type of IUD (Skyla, Liletta, Paragard, or Kyleena) or different birth control method (oral contraceptives, contraceptive patch, vaginal ring, Depo-Provera, etc. in a 5 year period. The only exception to this 5 year restriction is if the recipient meets one or more of the criteria listed below. If a recipient meets one or more of the criteria listed below she may qualify for another Mirena IUD within a 5 year period.

1. Recipient develops high blood pressure or any other medical condition that would allow for a progestin only method.

2. Any nulliparous woman who has a spontaneous expulsion within 6 months of placement.

3. Mirena IUD is removed to allow a pregnancy. Once delivered, recipient is eligible for another Mirena IUD.

4. Surgical removal of an embedded IUD in an office or outpatient setting.

In order to receive reimbursement, providers will need to submit a clean claim and medical records documenting the above mentioned criteria to the:

Plan First Program Manager
Alabama Medicaid Agency
Managed Care Division
P. O. Box 5624
Montgomery, AL 36103-5624

NOTE:

Effective January 1, 2012, intrauterine devices (IUDs) and implantable contraceptive devices will be reimbursed only when billed on a medical claim. Pharmacies will no longer be able to bill for these devices for a specific recipient and ship to the provider for insertion/implantation. Example devices include Mirena®, Paragard®, Nexplanon®, Liletta®, Kyleena® and Skyla®.

NOTE:

Effective 5/1/2012, Federally Qualified Health Centers and Rural Health Centers may submit claims for Mirena®, Paragard®, Liletta, Nexplanon®, and Kyleena® fee-for-service outside the encounter rate. FQHC and RHCs may submit a separate medical claim using the following procedure codes:

Mirena® - J7298	Skyla®- J7301
Paragard® - J7300	Liletta®- J7297
Nexplanon® – J7307	Kyleena® - J7296

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NOTE:

Effective 1/1/2014, the Skyla IUD is restricted to 1 every 3 years. The recipient **cannot** have another Skyla IUD, but may receive a different type of IUD (Mirena, Liletta, Paragard, or Kyleena) or different birth control method (oral contraceptives, contraceptive patch, vaginal ring, Depo-Provera, etc.).
The only exception to this 3 year restriction is if the recipient meets one or more of the criteria listed below. If a recipient meets one or more of the criteria listed below, she may qualify for another Skyla IUD within a 3 year period.

1. Recipient develops high blood pressure or any other medical condition that would allow for a progestin only method.

2. Any nulliparous woman who has a spontaneous expulsion within 6 months of placement.

3. Skyla IUD is removed to allow a pregnancy. Once delivered, recipient is eligible for another Skyla IUD.

4. Surgical removal of an embedded IUD in an office or outpatient setting.

In order to receive reimbursement, providers will need to submit a clean claim and medical records documenting the above mentioned criteria to the:

Plan First Program Manager
Alabama Medicaid Agency
Managed Care Division
P.O. Box 5624
Montgomery, AL 36103-5624

NOTE:

Effective 10/15/2018, the Liletta IUD is restricted to 1 every 5 years. The recipient **cannot** have another Liletta IUD, but may receive a different type of IUD (Mirena, Skyla, Paragard, or Kyleena) or different birth control method (oral contraceptives, contraceptive patch, vaginal ring, Depo-Provera, etc.). The only exception to this 5 year restriction is if the recipient meets one or more of the criteria listed below. If a recipient meets one or more of the criteria listed below, she may qualify for another Liletta IUD within a 5 year period.

1. Recipient develops high blood pressure or any other medical condition that would allow for a progestin only method.

2. Any nulliparous woman who has a spontaneous expulsion within 6 months of placement.

3. Liletta IUD is removed to allow a pregnancy. Once delivered, recipient is eligible for another Liletta IUD.

4. Surgical removal of an embedded IUD in an office or outpatient setting.

In order to receive reimbursement, providers will need to submit a clean claim and medical records documenting the above mentioned criteria to the:

Plan First Program Manager
Alabama Medicaid Agency
Managed Care Division
P.O. Box 5624
Montgomery, AL 36103-5624

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NOTE:

Effective for dates of service 9/1/2016, and thereafter, Medicaid began coverage of the Kyleena IUD. The Kyleena IUD is restricted to 1 every 5 years. The recipient **cannot** have another Kyleena IUD, but may receive a different type of IUD (Mirena, Skyla, Paragard, or Liletta) or different birth control method (oral contraceptives, contraceptive patch, vaginal ring, Depo-Provera, etc.). The only exception to this 5 year restriction is if the recipient meets one or more of the criteria listed below. If a recipient meets one or more of the criteria listed below, she may qualify for another Kyleena IUD within a 5 year period.

1. Recipient develops high blood pressure or any other medical condition that would allow for a progestin only method.

2. Any nulliparous woman who has a spontaneous expulsion within 6 months of placement.

3. Kyleena IUD is removed to allow a pregnancy. Once delivered, recipient is eligible for another Kyleena IUD.

4. Surgical removal of an embedded IUD in an office or outpatient setting.

In order to receive reimbursement, providers will need to submit a clean claim and medical records documenting the above mentioned criteria to the:

Plan First Program Manager
Alabama Medicaid Agency
Managed Care Division
P.O. Box 5624
Montgomery, AL 36103-5624

NOTE:

Effective 1/1/2008 the Nexplanon implant is restricted to 1 every 3 years. The recipient **cannot** have another Nexplanon implant but may receive an IUD (Mirena, Skyla, Paragard, or Liletta) or different birth control method (oral contraceptives, contraceptive patch, vaginal ring, Depo-Provera, etc.). The only exception to this 3 year restriction is if the recipient meets one or more of the criteria listed below. If a recipient meets one or more of the criteria listed below, she may qualify for another Nexplanon implant within a 3 year period.

1. Recipient develops high blood pressure or any other medical condition that would allow for a progestin only method.

2. Any nulliparous woman who has an embedded or migration of Nexplanon implant within 6 months of placement.

3. Nexplanon implant is removed to allow a pregnancy. Once delivered, recipient is eligible for another Nexplanon implant.

4. Surgical removal of an embedded or migration of Nexplanon implant in an office or outpatient setting.

In order to receive reimbursement, providers will need to submit a clean claim and medical records documenting the above mentioned criteria to the:

Plan First Program Manager
Alabama Medicaid Agency
Managed Care Division
P.O. Box 5624
Montgomery, AL 36103-5624

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Modifiers

Appropriate Use of Modifiers

Please refer to this CMS link for more information regarding NCCI edits: https://www.medicaid.gov/medicaid/program-integrity/national-correct-coding-initiative-medicaid/index.html

Modifier 25 (Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service)
It may be necessary to indicate that on the day a procedure or service identified by CPT code was performed, the recipient's condition required a significant, separately identifiable E&M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E&M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E&M service to be reported.

BMI Requirements

Plan First providers that bill procedure codes 99205, 99212, 99213, or 99214 must include a BMI diagnosis on the claim or the claim will be denied. In instances where a BMI cannot be determined (e.g., wheelchair bound recipients) an override request may be submitted after the claim has been filed and denied. See Chapter 40 for Override request procedures.

The table below provides a description of procedure codes and ICD-10 codes that require a percentile on the CMS 1500 claim form for **recipient's age 8-19 years**:

Procedure Code Description	ICD-10 Diagnosis Code Description for Ages 8-19
99205 Office/Outpatient Visit New 99212 Office/Outpatient Visit Est 99213 Office/Outpatient Visit Est 99214 Office/Outpatient Visit Est	Z6851 BMI Pediatric, Less Than 5th Percentile for Age Z6852 BMI Pediatric, 5th Percentile to Less Than 85% for Age Z6853 BMI Pediatric, 85% To Less Than 95th Percentile for Age Z6854 BMI Pediatric, Greater Than or Equal To 95% for Age

The table below provides a description of procedure codes and ICD-10 codes that require a BMI on the CMS 1500 claim form for **recipients age 20 and older**:

Procedure Code Description	ICD-10 Diagnosis Code Description For Ages 20 and Older
99205 Office/Outpatient Visit New 99212 Office/Outpatient Visit Est	Z681 Body Mass Index (BMI) 19 Or Less, Adult Z6820 Body Mass Index (BMI) 20.0-20.9, Adult Z6821 Body Mass Index (BMI) 21.0-21.9, Adult Z6822 Body Mass Index (BMI) 22.0-22.9, Adult Z6823 Body Mass Index (BMI) 23.0-23.9, Adult Z6824 Body Mass Index (BMI) 24.0-24.9, Adult Z6825 Body Mass Index (BMI) 25.0-25.9, Adult Z6826 Body Mass Index (BMI) 26.0-26.9, Adult

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99213 Office/Outpatient Visit Est 99214 Office/Outpatient Visit Est	Z6827	Body Mass Index (BMI) 27.0-27.9, Adult
	Z6828	Body Mass Index (BMI) 28.0-28.9, Adult
	Z6829	Body Mass Index (BMI) 29.0-29.9, Adult
	Z6830	Body Mass Index (BMI) 30.0-30.9, Adult
	Z6831	Body Mass Index (BMI) 31.0-31.9, Adult
	Z6832	Body Mass Index (BMI) 32.0-32.9, Adult
	Z6833	Body Mass Index (BMI) 33.0-33.9, Adult
	Z6834	Body Mass Index (BMI) 34.0-34.9, Adult
	Z6835	Body Mass Index (BMI) 35.0-35.9, Adult
	Z6836	Body Mass Index (BMI) 36.0-36.9, Adult
	Z6837	Body Mass Index (BMI) 37.0-37.9, Adult
	Z6838	Body Mass Index (BMI) 38.0-38.9, Adult
	Z6839	Body Mass Index (BMI) 39.0-39.9, Adult
	Z6841	Body Mass Index (BMI) 40.0-44.9, Adult
	Z6842	Body Mass Index (BMI) 45.0-49.9, Adult
	Z6843	Body Mass Index (BMI) 50-59.9, Adult
	Z6844	Body Mass Index (BMI) 60.0-69.9, Adult
	Z6845	Body Mass Index (BMI) 70 or Greater, Adult

C.12 Attachments

- STD/HIV Screening and Documentation Forms (Form 189)
- Sterilization Consent Form (Form 193)
- Sterilization Consent Form Detailed Instructions Guide
- Checklist for Consent Form Completion

These handouts are available through the Communications Division (334-353-4099)

- Folic Acid for Women for healthy babies (Handout)
- Birth Control Method Sheets (Handout)
- STD/HIV Screening and Documentation Forms
- Sterilization Consent Form

NOTE:

Please go to the Alabama Medicaid Agency web site to access the Alabama Medicaid Product Catalog for any forms that you may need to order. The web address is www.medicaid.alabama.gov.

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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.

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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."

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:

Retest Results (Date) _____
Positive Negative Indeterminate

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- ❑ Mental Health_____
- ❑ Partner notification services _____
- ❑ Other Health Care Provider_____
- ❑ Social Services_____
- ❑ Retesting
- ❑ Other_____

Follow-up Notes:

Additional Post- test counseling

Reason:

Points covered:

Signature/title of counselor _____ Date _____

Form 189 Alabama Medicaid Agency

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ALABAMA MEDICAID AGENCY STERILIZATION CONSENT FORM

NOTICE: YOUR DECISION AT ANY TIME TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITH HOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

CONSENT TO STERILIZATION

I have asked for and received information about sterilization from

_____
Physician or 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 Temporary Assistance for Needy Families (TANF) 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

_____
Specify Type of Operation

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, _____
Name of the Recipient

hereby consent of my own free will to be sterilized by

_____
Physician or Clinic

by the method called _____.
Specify Type of Operation

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: 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.

X_____ X_____
Recipient's Signature Date

_____
Type/Print Recipient's Name

_____
Recipient's Medicaid Number

INTERPRETER'S STATEMENT

If an interpreter is provided to assist the recipient to be sterilized: I have translated the information and advice presented orally to the recipient 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's Signature Date

Form 193 (Rev. 9-26-2016)

STATEMENT OF PERSON OBTAINING CONSENT

Before _____
Name of the Recipient

signed the consent form, I explained to him/her the nature of the sterilization operation _____, the
Specify Type of Operation

fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the recipient 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 recipient 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 recipient 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.

X_____ X_____
Signature of Person Obtaining Consent Date

_____
Type or Print Name

_____
Facility

_____
Address

PHYSICIAN'S STATEMENT

Shortly before I performed a sterilization operation upon

_____ on X_____
Name of the Recipient Date of Sterilization

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 recipient 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 recipient 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 recipient 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 recipient'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 recipient'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 recipient's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

☐ Premature delivery
Recipient's expected date of delivery: _____

☐ Emergency abdominal surgery **(describe circumstances in an attachment)**

X_____ X_____
Physician's Signature Date

Type/Print Name _____

NPI Number _____

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Sterilization Consent Form Detailed Instructions Guide

It is the responsibility of the **performing surgeon to submit a legible completed** copy of the Sterilization Consent Form (Form 193) **after** the surgery to Medicaid's fiscal agent, Gainwell Technologies (Gainwell). Consent forms should not be submitted to Gainwell prior to the surgery date. Receipt of multiple consent forms slows down the consent form review process and payment of claims. For timely processing, providers must complete all required fields and the performing surgeon must submit a copy of the recipient's signed Sterilization Consent Form to Gainwell using the Provider Web Portal upload process or via the fax number listed below:

Gainwell
ATTN: Medical Policy Unit/Consent Forms
Fax Number: (334) 215-7416

If submitting this form via fax, a barcode fax coversheet is required with each submission and should be included as page one of the fax transmission for the corresponding Record ID.

Effective November 28, 2016, Gainwell will not accept Consent Forms and supporting documentation in paper format. Consent Forms and supporting documents submitted to Gainwell in paper format on/after November 28, 2016 will be returned to the provider.

ONLY an electronic fillable version of the Sterilization Consent Form can be faxed to Gainwell. **The electronic fillable version of the Sterilization Consent Form** is located on the Alabama Medicaid's website at the following link:
http://www.medicaid.alabama.gov/documents/9.0_Resources/9.4_Forms_Library/9.4.3_Consent_Forms/9.4.3_Form_193_Consent_Sterilization_Fillable_9-26-16.pdf

The electronic fillable version must be printed to complete the signatures and dates. **All SIGNATURES AND DATES MUST BE COMPLETED IN BLACK INK TO ENSURE FAXED COPIES ARE LEGIBLE.**

Note: Gainwell will **not** accept any Sterilization Consent Forms by **email**.

Reference Section C.3.3 for updates regarding the digital submission of the Sterilization Consent Form and supporting documentation effective October 26, 2016.

All blanks on the Sterilization Consent Form must be appropriately completed. Gainwell will **NOT** pay any claims to **ANY** provider until a correctly completed **Alabama Medicaid Agency Sterilization Consent Form (Form 193)** is on file at Gainwell.

Gainwell will return forms to the provider upon identification of missing or invalid information in correctable fields. **Consent forms submitted to Gainwell with missing and/or invalid information in *NON-CORRECTABLE FIELDS [Fields 7, 8, (12 & 13, if provided), 16 and 17] of the consent form will be denied by Gainwell and not returned to the provider, therefore all claims associated with the sterilization WILL NOT BE PAID.**

Before sending the consent form to Gainwell, it is imperative that the **date of surgery** be clarified by reviewing the operative note to remedy claim denials due to incorrect date of surgery.

NOTE:
A *NON-CORRECTABLE FIELD is a field that cannot be changed, edited or revised once the Sterilization Consent Form has been submitted to Gainwell.

Missing and/or invalid information in a *NON-CORRECTABLE FIELD will cause the consent form to be denied , which WILL result in NONE-PAYMENT of ALL providers claims.

NOTE:
All **signature** and **date** lines on the Sterilization Consent Form noted with an **"X"** must be completed after the form is printed.

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CONSENT TO STERILIZATION INSTRUCTIONS		
Filed	**Description**	**Instructions**
1	Name of physician or clinic	Enter the typed or printed name of the physician or clinic that will provide information about the sterilization.
2	Specify type of operation	Enter of the type of operation that will be performed.
	Recipient's date of birth	Enter the recipient's date of birth in the following format: **month/day/year**. **Note: The recipient must be at least 21 years of age at the time consent is obtained. If the recipient was not 21 years of age when the Sterilization Consent Form was signed, the consent form will be denied.**
4	Recipient's name	Enter the typed or printed first and last name of the recipient.
5	Name of physician or clinic	Enter the typed or printed name of the physician or clinic that will perform the operation.
6	Specify type of operation	Enter of the type of operation that will be performed.
*7	Recipient's signature	The recipient must sign his/her first and last name. *(If the patient is unable to sign their name, the physician's office is responsible for documenting the reason why, either on the consent form or on attached documentation. If the individual consenting to sterilization is unable to write at all, due to a physical disability, they should have someone sign for them, in the presence of a witness. The witness **must** be someone other than those individuals required by regulations to be parties to the consent process. Therefore, the witness cannot be the person obtaining consent, the interpreter, or the physician. This same process should be used when the individual cannot write his or her name and signs with an "X".)* ***Note: The recipient's signature on the Sterilization Consent Form is considered a NON-CORRECTABLE FIELD and cannot be changed, edited or revised once submitted to Gainwell.**

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CONSENT TO STERILIZATION INSTRUCTIONS		
Filed	**Description**	**Instructions**
*8	Date recipient signed	The recipient must provide the date the Sterilization Consent Form was signed. • The date of the recipient's signature must be in the following format: **month/day/year**. • The required 30-day waiting period is calculated from this date. • The recipient's signature date must reflect at least **30 days**, but not more than **180 days** have passed prior to the procedure being done, except in the case of premature delivery or emergency abdominal surgery. • This date must be added at the time the recipient signs the form. • The date cannot be altered or added at a later date. ***Note: The date the recipient signed the Sterilization Consent Form is considered a NON-CORRECTABLE FIELD and cannot be changed, edited or revised once submitted to Gainwell.**
9	Recipient's name	Enter the typed or printed first and last name of the recipient.
10	Recipient's Medicaid Number	Enter the recipient's 13-digit Alabama Medicaid number.
INTERPRETER'S STATEMENT		
11	Language	Enter the language used by the interpreter to communicate the information to the recipient. **Note: If an interpreter is used, this section must be completed in full. If an interpreter is not used, N/A can be written into this section. If this section is blank, the Sterilization Consent Form will be returned to the provider for correction.**

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CONSENT TO STERILIZATION INSTRUCTIONS		
Filed	**Description**	**Instructions**
*12	Interpreter's signature	The interpreter must sign the Sterilization Consent Form on the same day the recipient signs. ***Note: The signature of the interpreter of the Sterilization Consent Form is considered a NON-CORRECTABLE FIELD and cannot be changed, edited or revised once submitted to Gainwell.**
*13	Date of interpreter's signature	The interpreter must date the form in the following format: **month/day/year**. The interpreters' date must coincide, be the same, as the date provided by the recipient. ***Note: The date of the signing of the Sterilization Consent Form by the interpreter is considered a NON-CORRECTABLE FIELD and cannot be changed, edited or revised once submitted to Gainwell.**
STATEMENT OF PERSON OBTAINING CONSENT		
14	Recipient's name	Enter the typed or printed first and last name of the recipient.
15	Specify type of operation	Enter the type of operation that will be performed.
*16	Signature of person obtaining consent	The person obtaining consent must sign the Sterilization Consent Form at the same time or after the recipient, but **PRIOR** to the date of sterilization. ***Note: The signature of the person obtaining consent is considered a NON-CORRECTABLE FIELD and cannot be changed, edited or revised once submitted to Gainwell.**
*17	Date of signature of person obtaining consent	The person obtaining consent must date the form in the following format: month/day/year. The person obtaining consent signature date will reflect at least **30 days**, but not more than **180 days** have passed prior to the procedure being done. ***Note: The date of the person obtaining consent is considered a NON-CORRECTABLE FIELD and cannot be changed, edited or revised once submitted to Gainwell.**

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CONSENT TO STERILIZATION INSTRUCTIONS		
Filed	**Description**	**Instructions**
18	Name of person obtaining consent	Enter the typed or printed first and last name of the person obtaining consent.
19	Facility name	Enter the name of the facility where the recipient received counseling.
20	Facility address	Enter the address of the facility where the recipient received the sterilization information.
PHYSICIAN'S STATEMENT		
21	Recipient's name	Enter the typed or printed first and last name of the recipient.
22	Date of sterilization	Enter the date the sterilization was performed in the following format: **month/day/year**. NOTE: It is imperative that the date of surgery be clarified by reviewing the operative note to remedy claims denials due to an incorrect date of surgery.
23	Specify type of operation	Enter the type of operation that will be performed.
24	Instructions for use of alternative final paragraphs	Cross out the paragraph, which is not used. • At least thirty days have passed between the date of the recipient's signature on the Sterilization Consent Form and the date the sterilization was performed. • This sterilization was performed less than **30 days** but more than **72 hours** after the date of the recipient's signature on this Sterilization Consent Form because of the following circumstances **(check applicable box and fill in information requested):** ☐ Premature delivery Recipient's expected date of delivery: ☐ Emergency abdominal surgery **(describe circumstances in an attachment)** Enter the recipient's expected date of delivery in the following format: **month/day/year**.

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CONSENT TO STERILIZATION INSTRUCTIONS		
Filed	**Description**	**Instructions**
25	Physician's signature	The physician's signature can only be affixed after the sterilization procedure is performed. This field must contain the signature of the physician who performed the procedure. Signature stamps are not permissible in this field. **Note: The physician may sign on the same day of the procedure or any time after the sterilization procedure is performed.**
26	Date of physician's signature	The date of the physician's signature must be in the following format: **month/day/year**, and must be on or after the date of the surgery.
27	Name of the physician	Enter the type or printed first and last name of the physician.
28	Medicaid Provider Identifier Number (NPI)	Enter the physician's National Provider Identifier (NPI).

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ALABAMA MEDICAID AGENCY STERILIZATION CONSENT FORM

NOTICE: YOUR DECISION AT ANY TIME TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITH HOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

CONSENT TO STERILIZATION

I have asked for and received information about sterilization from

Field 1
Physician or 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 Temporary Assistance for Needy Families (TANF) 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

Field 2
Specify Type of Operation

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 Field 3 (Month/Day/Year).

I, Field 4 (Name of the Recipient)

hereby consent of my own free will to be sterilized by

Field 5
Physician or Clinic

by the method called Field 6 (Specify Type of Operation).

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: 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.

X Field 7 (Recipient's Signature) X Field 8 (Date)

Field 9
Type/Print Recipient's Name

Field 10
Recipient's Medicaid Number

INTERPRETER'S STATEMENT

If an interpreter is provided to assist the recipient to be sterilized: I have translated the information and advice presented orally to the recipient to be sterilized by the person obtaining the consent. I have also read him/her the consent form in Field 11 language and explained its contents to him/her. To the best of my knowledge and belief, he/she understood this explanation.

Field 12
Interpreter's Signature

Field 13
Date

STATEMENT OF PERSON OBTAINING CONSENT

Before Field 14 (Name of the Recipient) signed the consent form, I explained to him/her the nature of the sterilization operation Field 15 (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 recipient 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 recipient 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 recipient 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.

X Field 16 (Signature of Person Obtaining Consent) X Field 17 (Date)

Field 18
Type or Print Name

Field 19
Facility

Field 20
Address

PHYSICIAN'S STATEMENT

Shortly before I performed a sterilization operation upon

Field 21 (Name of the Recipient) on X Field 22 (Date of Sterilization)

I explained to him/her the nature of the sterilization operation

Field 23
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 recipient 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 recipient 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 recipient 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 recipient'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 recipient'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 recipient's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

☐ Premature delivery
Recipient's expected date of delivery: Field 24

☐ Emergency abdominal surgery **(describe circumstances in an attachment)**

X Field 25 (Physician's Signature) X Field 26 (Date)

Type/Print Name Field 27

NPI Number Field 28

Form 193 (Rev 9-26-2016)

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Checklist for Consent Form Completion

Sterilization Claim & Primary Surgeon's Responsibility

It is the responsibility of the performing surgeon to submit a copy of the sterilization consent form to Gainwell. Providers other than performing surgeon should not submit a copy of consent form to Gainwell. Receipt of multiple consent forms slows down the consent form review process and payment of claims. Therefore, please do not forward copies of completed consent forms to other providers for submission to Gainwell.

When the claim for the sterilization procedure is submitted to Gainwell, the claim will suspend in the system for 35 days waiting for the approved consent form to be entered. The Saturday after the claim is keyed into the system, it will check to see if the consent form has been entered. It will check the system each Saturday, up to 35 days, for the approved consent form. After the 35tht day, the claim will deny for no consent form on file. If the approved consent form is found in the system during the 35 days, it will process the claim on the Saturday it finds the form.

Sterilization Consent Form

Clarification of the completion of the sterilization consent form reflecting CMS regulations and Alabama Medicaid policy (refer to the current Appendix C of the Alabama Medicaid Provider Manual and 42CFR50

a) All blanks on the consent form must be appropriately completed before the State may pay the provider for sterilization procedure.

b) The "Consent to Sterilization" must be signed by the person to be sterilized at least thirty days prior to the procedure date. The birth date must indicate the person to be at least twenty-one (21) years of age on the date the signature was obtained.

c) The interpreter, if one is used, must sign and date the consent the same day the recipient signs. In instances where the interpreter signs any date other than the date recorded by the recipient, the claim will be denied. If no interpreter is used, this section of the form must be marked as "not applicable" (N/A). If the Interpreter's Statement is signed and dated, please complete the "form of language" line also.

d) When it is not known in advance which specific physician will perform the procedure, it is acceptable to list a generic description of the physician, i.e. "staff physician, on-call physician, OB/GYN physician". When using a generic description and not a specific physician's name, the patient is to be informed that the physician on call or on duty will perform the procedure. The name of the provider facility (hospital, surgical center, etc.) or provider physician's group must also be entered in the same blank containing the generic physician description when the generic physician description is used. The physician who is named in the first paragraph of the consent form does not have to be the physician who performs the surgery and signs the "Physician's Statement".

e) Signature of person obtaining consent: The individual obtaining consent must sign after the recipient (may sign the same day as the recipient, as long as the recipient signs first) but prior to the procedure in order to properly document informed consent. In instances where the person obtaining consent does not sign prior to the procedure date, (date-wise – not time) the claim will be denied. In other words, denial will occur if the date of the signature of the person obtaining consent and the procedure date is the same or any date after the procedure date.

f) Procedure recorded in physician's statement: It is necessary for the recipient (by signature) to give consent in understanding their rights relative to the sterilization. Both sections of the form should indicate the same type of procedure; however, it is not necessary that the wording of the procedure/manner in which the sterilization is performed be identical under both sections of the form.

Most frequent causes of claims having to be returned for correction:	**Reasons consent forms and associated claims will be denied:**
1. Recipient's date of birth not the same on the claim and consent form.	1. Missing recipient signature.
2. Expected date of delivery not provided when the sterilization procedure is performed less than the required 30-day waiting period.	2. Missing or invalid date of recipient signature, including less than 30 days prior to procedure.
3. Expected date of delivery is recorded but indicator for premature delivery or emergency surgery is not checked.	3. Recipient under age 21 on date consent form was signed.
4. All blanks not appropriately completed.	4. Missing signature of person obtaining consent.
5. Physician's signature is missing.	5. Missing or invalid date of person obtaining consent, including date of procedure, or any later date.
6. Date of sterilization not the same on the claim and on the consent form	6. Missing interpreter signature (if one was used).

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7. Legibility of dates and signatures.	7. Missing or invalid date of interpreter, including any date other than the date the recipient signed (if one was used).
8. Facility name not on the consent form.	8. Sterilization performed less than 72 hours after the date of the recipient signature on the consent form in cases of premature delivery and emergency abdominal surgery.

*** As a reminder if these guidelines are not followed, Gainwell will deny the consent form. ***

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D DMH Non-Emergency Transportation

The Non-Emergency Transportation Program for the Alabama Department of Mental Health provides necessary non-ambulance one-way or round trip transportation for Medicaid recipients to a Medicaid covered mental health rehabilitation service.

D.1 Eligible Providers

Alabama Department of Mental Health contractors enrolled in the Medicaid program to provide mental Illness and substance abuse rehabilitation services.

D.2 Covered Service

The ADMH NET Program may be utilized for transportation of a Medicaid recipient to an authorized location for receipt of a covered mental illness or substance abuse rehabilitation service as specified in Chapter 105 of the Alabama Medicaid Agency Provider Manual. Receipt of the service must occur on the same date as the transportation event.

NET must be provided in compliance with written policies and procedures developed and maintained by the ADMH contractor which include, at a minimum, the following specifications:

- Non-emergency transportation services linked to a Rehabilitative service in which medical necessity must be established.
- All vehicles used for the transportation shall have properly operating seat belts or child restraint seats, and provide for seasonal comfort with properly functioning heat and air.
- All vehicles used for transportation shall be in good repair and have documentation of regular maintenance inspections.
- The number of individuals permitted in any vehicle shall not exceed the number of seats, seat belts, and age appropriate child restraint seats as permitted to be operated under the safety standards for the make of that model vehicle.
- All vehicles operated by the provider shall carry:
    a. Proof of accident and liability insurance.
    b. Documentation of the vehicle’s ownership.
    c. A fire extinguisher and first aid kit for company owned vehicles.
- The driver of any vehicle used to transport recipients shall:
    a. Be at least nineteen (19) years old;

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b. Be in possession of a valid driver's license for the type of vehicle used in transporting recipients;

c. Carry, at all times, the name(s) and telephone number(s) of the performing provider's staff to notify in case of a medical or other emergency;

d. Be prohibited from the use of alcohol, drugs, tobacco products, cellular phones or other mobile devices, or from eating while driving;

e. Be prohibited from leaving a minor unattended in the vehicle at any time;

f. Be prohibited from making stops between authorized destinations, altering destinations, and taking recipients to unauthorized locations. In the event of emergency, unscheduled stops are permitted. In these occasions, the driver must contact the supervisor for instructions.

- The performing provider shall provide an adequate number of staff for supervision of individuals transported to ensure passenger safety.

D.3 Service Documentation

D.3.1 Mental Illness

The Medicaid recipient's service record must fully document the rehabilitation option service provided on the date of the transportation event. The treatment plan will indicate the referral to NET services. A transportation signature log can be used to document transportation to a day program. Recipient signatures for individual/group or other rehabilitation option services will document the transportation for those services. Transportation must be an indicated service on the case plan if transportation is provided by a case manager.

D.3.2 Substance Abuse

The service record must fully document the extent and nature of the non-emergency transportation provided, including:

- Medical necessity for non-emergency transportation.
- Treatment/service plan authorization by a licensed practitioner of the healing arts.
- Medicaid rehabilitation service to which transportation was provided and the date of this service.
- Date of NET.
- Destination.
- Mode of transportation.
- Miles traveled.
- Signature of the Medicaid recipient.
- Signature of the direct service provider.

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D.4 Billing Restrictions

Reimbursement will not be provided for:

- Transportation to any services other than Medicaid Mental Health Rehabilitation Services.
- Services that are not medically necessary or that are not provided in compliance with the provisions of this chapter.

D.5 Reporting Code

Mental Illness: T2002-HE

Substance Abuse: T2002-HF; T2002-HF: HA; T2002-HF: HD; T2002-HF: HH; T2002-HF: HA: HH

D.6 Billing Units

Episode = round trip

D.7 Maximum Units

One episode per day, per recipient, per provider.

D.8 Rate

$17.00/Episode

D.9 Billing Reporting Combination Restrictions

There is no billing reporting combination restrictions.

D.10 Cost Sharing (Copayment)

The copayment does not apply to services provided by transportation providers or to recipients receiving rehabilitative services.

D.11 Billing Recipients

By filing a claim with the Medicaid Program, a provider is agreeing to accept assignment and by accepting assignment, the provider agrees to accept the Medicaid reimbursement, plus any cost-sharing amount (copay) to be paid by the recipient, as payment in full for those services covered under the Medicaid Program. The Medicaid recipient, or others on his behalf, must not be billed for the amount above that, if any, which is paid on an allowed service.

D.12 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

Transportation providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions

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- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When filing a claim on paper, a CMS-1500 claim form is required. Medicare-related claims must be filed using the Medical Medicaid/Medicare-related Claim Form.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

D.12.1 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.

D.12.2 Diagnosis Codes

The *International Classification of Diseases - 10th Revision - Clinical Modification* (ICD-10-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, AMA Plaza 330 North Wabash Ave, Suite 39300 Chicago, IL 60611-5885, or 1-800-621-8335.

NOTE:

ICD-9 codes should be used for claims submitted with dates of service prior to or equal to 09/30/2015.

ICD-10 codes should be used for claims submitted with dates of service on/after 10/01/2015.

NOTE:

ICD-9 diagnosis codes, within the range of 290-316 for ICD-9 or F0150-F99 for ICD-10, must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field. The V code unspecified psychosocial circumstance is covered only for children and adolescents or adults receiving DHR protective services. Claims filed for pregnant women (SOBRA) must include V222 for ICD-9 or Z33.1 for ICD-10 (pregnant state, incidental) as well as the appropriate MI/SA diagnosis code.

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E Forms

This section contains examples of various Alabama Medicaid forms used in documenting medical necessity and claims processing.

The following forms may be obtained by contacting the following:

Form Name	*Contact*	*Phone*
Certification and Documentation of Abortion	Communications	(334) 353-5203
Check Refund Form	Gainwell Provider Assistance Center	(800) 688-7989
Dental Prior Authorization Form	Gainwell Provider Assistance Center	(800) 688-7989
Hysterectomy Consent Form	Communications	(334) 353-5203
Patient Status Notification (Form 199)	Gainwell Provider Assistance Center	(800) 688-7989
Prior Authorization Form	Gainwell Provider Assistance Center	(800) 688-7989
Sterilization Consent Form	Communications	(334) 353-5203
Family Planning Services Consent Form	Communications	(334) 353-5203
Prior Authorization Request	Clinical Services and Support	(334) 242-5050
Prior Authorization Change Request	Clinical Services and Support	(334) 242-5149
Early Refill DUR Override	Clinical Services and Support	(334) 242-5050
Growth Hormone For AIDS Wasting	Clinical Services and Support	(334) 242-5050
Growth Hormone For Children	Clinical Services and Support	(334) 242-5050
Adult Growth Hormone	Clinical Services and Support	(334) 242-5050
Maximum Unit Override	Clinical Services and Support	(334) 242-5050
Miscellaneous Medicaid Pharmacy PA Request Form	Clinical Services and Support	(334) 242-5050
EPSDT Child Health Medical Record	Communications	(334) 353-5203
Alabama Medicaid Agency Referral Form	Communications	(334) 353-5203
Residential Treatment Facility Model Attestation Letter	Institutional Services Unit	(334) 353-3206
Certification of Need for Services: Emergency Admission to a Residential Treatment Facility	Institutional Services Unit	(334) 353-3206
Certification of Need for Services: Non-Emergency Admission to a Residential Treatment Facility	Institutional Services Unit	(334) 353-3206
PCP Override Request Form	Managed Care Network Provider Assistance Unit	(334) 353-5907
Request for Administrative Review of Outdated Medicaid Claim	System Support Unit	(334) 242-5562
Request for National Correct Coding Initiative (NCCI) Administrative Review	System Support Unit	(334) 353-1747
Request for NCCI Redetermination Review	Gainwell Provider Assistance Center	(800) 688-7989
Medicaid Other Insurance	Gainwell Provider Assistance	(800) 688-7989

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Form Name	*Contact*	*Phone*
Attachment Form	Center	
Medical Medicaid/Medicare Related Claim Form	Gainwell Provider Assistance Center	(800) 688-7989
Request for Medical Utilization Redetermination (First Level of Appeal)	System Support Unit	(334) 353-1747
Request for Medical Utilization Redetermination (Second Level of Appeal)	System Support Unit	(334) 353-1747

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E.1 Certification and Documentation of Abortion

ALABAMA MEDICAID AGENCY

Certification and Documentation

For Abortion

I, _____, certify that the woman, _____, suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself that would place the woman in danger of death unless an abortion is performed.

Name of Patient	*Patient's Medicaid Number*
Patient's Street Address	*City* / *State* / *Zip*
Printed Name of Physician	*Physician's NPI #*
Signature of Physician	*Date Physician Signed*
By entering my name above I agree to the contents of this document.	
Date of Surgery	

INSTRUCTIONS: The physician **must** submit this form via Provider Web Portal upload or fax with the supporting medical records and claim to HPE.

Refer to Chapter 5, Filing Claims, for instructions on the digital submission of this form and supporting documentation.

NOTE: If submitting this form via fax, a barcode fax coversheet is required with each submission and should be included as page one of the fax transmission for the corresponding Record ID.

Fax form to HPE at: (334) 215-7416.

PHY-96-2 (Revised 09/29/16) Alabama Medicaid Agency

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E.2 Check Refund Form

Check Refund Form (REF-02)

Mail To: HPE
Refunds
P.O. Box 241684
Montgomery, AL 36124-1684

Provider Name _____ NPI Number_____

Check Number_____ Check Date _____ Check Amount _____

Information needed on each claim being refunded	Claim 1	Claim 2	Claim 3
13-digit Claim Number (from EOP)			
Recipient's ID Number (from EOP)			
Recipient's name (Last, First)			
Date(s) of service on claims			
Date of Medicaid payment			
Date(s) of service being refunded			
Service being refunded			
Amount of refund			
Amount of insurance received, if applicable			
Insurance Co. name, address, and policy number, if applicable			
Reason for return (see codes listed below)			

1. BILL: An incorrect billing or keying error was made
2. DUP: A payment was made by Alabama Medicaid more than once for the same service(s)
3. INS: A payment was received by a third party source other than Medicare
4. MC ADJ: An over application of deductible or coinsurance by Medicare has occurred
5. PNO: A payment was made on a recipient who is not a client in your office
6. OTHER: (Please explain)

_____

_____

Signature _____ Date _____ Telephone_____

Revised 01/06/16

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E.3 Alabama Prior Review and Authorization Dental Request

ALABAMA PRIOR REVIEW AND AUTHORIZATION DENTAL REQUEST

Section I – Must be completed by a Medicaid provider.

Requesting NPI or License #_____

Phone ( ) _____

Name _____

Address _____

City/State/Zip _____

Medicaid Provider NPI # _____

Section II

Medicaid Recipient Identification Number _____

(13-digit RID number is required)

Name as shown in Medicaid system _____

Address _____

City/State/Zip _____

Telephone Number ( ) _____

Section III DATES OF SERVICE START CCYYMMDD	STOP CCYYMMDD	REQUIRED PROCEDURE CODE	QUANTITY REQUESTED	TOOTH NUMBER(S) OR AREA OF THE MOUTH
PLACE OF SERVICE (Circle one)				
11 = DENTAL OFFICE				
22 = OUTPATIENT HOSPITAL				
21 = INPATIENT HOSPITAL				

Section IV

1. Indicate on the diagram below the tooth/teeth to be treated.

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

2. Detailed description of condition or reason for the treatment:

_____

_____

_____

_____

3. Brief Dental/Medical History: _____

_____

_____

_____

_____

Certification Statement: This is to certify the requested service, equipment, or supply is medically indicated and is reasonable and necessary for the treatment of this patient. This Form and any statement on my letterhead attached hereto have been completed by me or by my employee and reviewed by me. The foregoing information is true, accurate, and complete, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Signature of Requesting Dentist _____ Date of Submission _____

FORWARD TO: HP, P.O. Box 244032, Montgomery, Alabama 36124-4032

Form 343
Revised 5/28/13

Alabama Medicaid Agency
www.medicaid.alabama.gov

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E.4 Hysterectomy Consent Form

ATTACHMENT I

ALABAMA MEDICAID AGENCY HYSTERECTOMY CONSENT FORM

See the back of this form for instructions on completing and submitting the form

PART I. PHYSICIAN

Certification by Physician Regarding Hysterectomy

I hereby certify that I have advised _____ (Name of Patient) Medicaid Number _____ to undergo a hysterectomy because of the diagnosis of _____ _____ (diagnosis code). Further, I have explained orally and in writing to this patient and/or her representative (_____ Name of Representative, if any) that she will be permanently incapable of reproducing as a result of this operation which is medically necessary. This explanation was given before the operation was performed.

_____ Name of Physician

_____ NPI #

_____ Signature of Physician

_____ Date of Signature

PART II. PATIENT

Acknowledgment by Patient (and/or Representative) of Receipt of Above Hysterectomy Information

I, _____ Name of Patient _____ Date of Birth and/or _____ 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 given to me before the operation.

_____ Signature of Patient

_____ Date

_____ Signature of Representative, if any

_____ Date

PART III. PHYSICIAN

Date of Surgery _____

PART IV. UNUSUAL CIRCUMSTANCES

Recipient Name: _____ Recipient ID: _____

I _____ Printed name of physician certify

☐ patient was already sterile when the hysterectomy was performed. Cause of sterility _____. Medical records are attached.

☐ hysterectomy was performed under a life threatening situation. Medical records are attached.

☐ hysterectomy was performed under a period of retroactive Medicaid eligibility. Medical records are attached.

Before the operation was performed, I informed the recipient that she would be permanently incapable of reproducing as a result of this operation. ☐ Yes ☐ No

Signature: _____ Date: _____

PART V. STATE REVIEW DECISION

Signature of Reviewer: _____ Date of Review: _____ ☐ Pay ☐ Deny

Reason for denial: _____

PHY-81243 (Revised 09-29-2016) *Alabama Medicaid Agency*

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Hysterectomy Form Instructions

Part I.

This section is required for all routine hysterectomies. See Part III and IV for a patient who is already sterile, a hysterectomy performed under life-threatening emergency or during a period of retroactive Medicaid eligilbity.

- Enter the name of the patient.
- Enter the recipient's 13 digit Medicaid Number.
- Enter the diagnosis description requiring hysterectomy.
- Enter the diagnosis code.
- Enter the name of the representative if the recipient is unable to sign the consent form. If a representative is not used enter N/A in the field.
- Enter name of the physician who will perform the hysterectomy.
- Enter the NPI Number of the physician who will perform the hysterectomy.
- Physician must sign their name and enter the date of signature. Date must be the date of the surgery or a prior date. **If any date after surgery is recorded, the form will be denied.**

Part II.

This section is required for all routine hysterectomies. See Parts III and IV for a patient who is already sterile, a hysterectomy performed under a life-threatening emergency or during a period of retroactive Medicaid eligibility.

- Enter the name of the patient and the patient's date of birth including the day/month/year.
- Enter the name of representative if the recipient is unable to sign the consent form. If a representative is not used, record N/A in this field.
- Patient must sign and enter the date of signature unless a representative is being used to complete the form. Date must be the date of surgery or a prior date. **If any date after surgery is recorded, the form will be denied.**
- Representative must sign and enter the date of signature if the recipient is unable to sign the consent form. Date must be the date of the surgery or a prior date. **If any date after surgery is recorded, the form will be denied.**

PART III.

This section is required for all hysterectomies.

- Enter the date of surgery once the surgery has been performed.

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E.5 Patient Status Notification (Form 199)

MEDICAID PATIENT STATUS NOTIFICATION

(To be submitted when a patient is admitted, discharged, transferred, or expires)

TO: Alabama Medicaid Agency
P.O. Box 5624–36103
501 Dexter Avenue
Montgomery, Alabama 36104

Date _____

FROM: _____ NPI Number _____
(Name of Facility)

_____ Telephone Number _____
(Address of Facility)

CURRENT PATIENT STATUS

Patient's First Name M.I. Patient's Last Name

_____/_____/_____ Birthdate _____

Patient's Social Security No. ☐☐☐☐☐☐☐☐☐ Female ☐

Patient's Medicaid No. ☐☐☐☐☐☐☐☐☐☐☐☐☐ Male ☐

Date Admitted _____/_____
(Medicare Admission) (Medicaid Admission)

Number of Medicare Days this Admission: _____

For Medicaid Use Only:
Over 60–days late _____
Medicare Denial: _____

☐ New Admission ☐ Hospital ☐ Mental Institutuion

☐ Re–Admission From: ☐ Home

☐ Transferred Admission ☐ Other Nursing Home _____

Reference Information: _____
Name of Sponsor

_____
Address of Sponsor

☐ Mental Illness ☐ Developmentally Disabled

☐ Convalescent Care ☐ Post Extended Care Days ☐ Swing Bed Approved By _____

☐ Dual Diagnosis ☐ Mental Retardation Date Approved: _____

PATIENT DISCHARGE STATUS

Discharged to: _____ Date _____

Death (Date) _____

Signed _____

Title _____

Distribution:
White: Alabama Medicaid Agency
Canary: Office of Determination for Medicaid Eligibility - check one: ☐ SSI ☐ D.O.
Pink: Nursing Home File Copy

_____
District Office

Form 199 (Formerly XIX-LTC-4)
Revised 2-13-08

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THIS FORM MUST BE SUBMITTED TO MEDICAID WITHIN 60 DAYS OF MEDICAID ADMISSION DATE

Physician's current orders:
(a copy of orders may be attached)

PLEASE EXPLAIN REASON FOR HOSPITAL STAY OR POST EXTENDED CARE. (must be signed by an RN)

RN Signature

FOR POST EXTENDED HOSPITAL CARE ONLY:
(Please list nursing homes and dates they were contacted for placement. This form must be documented every 15 days.)

Nursing Home	Date Contacted

I CERTIFY THAT THIS RECIPIENT NEEDS NURSING HOME CARE
(Physician must sign and date)

Physician's Signature **Date**

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E.6 Alabama Prior Review and Authorization Request Form

You may fill in the blanks on the computer. Print the form and add signature and date. Mail completed form to HPE at the address below. Information that is typed in will not be saved in the form once the document is closed.

ALABAMA PRIOR REVIEW AND AUTHORIZATION REQUEST

(Required If Medicaid Provider) PMP ( )

Requesting Provider NPI #

Phone with Area Code

Name

Recipient Medicaid #

Name

Address

City/State/Zip

EPSDT Screening Date DOB

Prescription Date CCYYMMDD

Rendering Provider NPI #

Phone with Area Code

Fax with Area Code

Name

Address

City/State/Zip

Ambulance Transport Code

Ambulance Transport Reason Code

DME Equipment: New Used

First Diagnosis . Second Diagnosis .

Assignment/Service Code Patient Condition Prognosis Code

01	Medical Care	44	Home Health Visits	AD	Occupational Therapy
02	Surgical	54	LTC Waiver	AE	Physical Therapy
14	DME-Purchase	56	Medically-Related Transportation		
15	DME-Rental	59	Maternity	A4	Psychiatric*
35	Dental Care	72	Inhalation Therapy	AF	Speech Therapy
40	Oral Surgery	74	Private Duty Nursing	AL	Vision-Optometry
42	Home Health Care	75	Prosthetic Device	AO	Case Management

Line Item	DATES OF SERVICE START CCYYMMDD	DATES OF SERVICE STOP CCYYMMDD	PLACE OF SERVICE	PROCEDURE CODE*	MODIFIER 1	UNITS	COST/ DOLLARS

Clinical Statement: (Include Prognosis and Rehabilitation Potential) A current plan of treatment and progress notes, as to the necessity, effectiveness and goals of therapy services (PT, OT, RT, SP, Audiology, Psychotherapy, Oxygen Certifications, Home Health and Transportation) must be attached.

***If this PA is for Psychiatric or Inpatient stay, Procedure Code is not required.**

Certification Statement: This is to certify that the requested service, equipment, or supply is medically indicated and is reasonable and necessary for the treatment of this patient and that a physician signed order is on file (if applicable). This form and any statement on my letterhead attached hereto has been completed by me, or by my employee and reviewed by me. The foregoing information is true, accurate, and complete, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability .

Signature of Requesting Provider Date

FORWARD TO: HPE, P.O. Box 244036 Montgomery, Alabama 36124-4032

Form 342
Revised 4-2016

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Alabama Medicaid Agency
www.medicaid.alabama.gov

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E.7 Sterilization Consent Form

ALABAMA MEDICAID AGENCY STERILIZATION CONSENT FORM

NOTICE: YOUR DECISION AT ANY TIME TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITH HOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

CONSENT TO STERILIZATION

I have asked for and received information about sterilization from

_____
Physician or 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 Temporary Assistance for Needy Families (TANF) 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

_____
Specify Type of Operation

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, _____
Name of the Recipient

hereby consent of my own free will to be sterilized by

_____
Physician or Clinic

by the method called _____.
Specify Type of Operation

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: 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.

X _____ X _____
Recipient's Signature Date

_____
Type/Print Recipient's Name

_____
Recipient's Medicaid Number

INTERPRETER'S STATEMENT

If an interpreter is provided to assist the recipient to be sterilized: I have translated the information and advice presented orally to the recipient 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's Signature Date

Form 193 (Rev. 9-26-2016)

STATEMENT OF PERSON OBTAINING CONSENT

Before _____.
Name of the Recipient

signed the consent form, I explained to him/her the nature of the sterilization operation _____, the
Specify Type of Operation

fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the recipient 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 recipient 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 recipient 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.

X _____ X _____
Signature of Person Obtaining Consent Date

_____
Type or Print Name

_____
Facility

_____
Address

PHYSICIAN'S STATEMENT

Shortly before I performed a sterilization operation upon

_____ on X _____
Name of the Recipient Date of Sterilization

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 recipient 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 recipient 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 recipient 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 recipient'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 recipient'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 recipient's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

☐ Premature delivery
Recipient's expected date of delivery: _____

☐ Emergency abdominal surgery **(describe circumstances in an attachment)**

X _____ X _____
Physician's Signature Date

Type/Print Name _____

NPI Number _____

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E.8 Family Planning Services Consent Form

Name: _____
Medicaid Number: _____
Date of Birth: _____

I give my permission to _____ to provide family planning services to me. I understand that I will be given a physical exam that will include a pelvic (female) exam, Pap smear, tests for sexually transmitted diseases (STDs), tests of my blood and urine and any other tests that I might need. I have been told that birth control methods that I can pick from may include oral contraceptives (pills), Depo-Provera shots, intrauterine devices (IUDs), Norplant implant, diaphragms, foams, jellies, condoms, natural family planning or sterilization.

Signature: _____	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

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E.9 Prior Authorization Request Form

NOTE:

Prior Authorization Form 369 may be downloaded from the Medicaid website at www.medicaid.alabama.gov .

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E.10 Prior Authorization Change Request Form

Alabama Medicaid Agency
Prior Authorization (PA) Change Request

Supplier Information	
Contact Name:	
NPI:	
Phone Number:	

Recipient Information	
Recipient Name:	
Medicaid ID:	

Prior Authorization Number	

Reason for Change ***Please use this section to denote what field(s) on the PA request require a change.*** ***Complete all applicable fields below.*** ***Examples: Add/Change Modifier: Add "RR" to "E1088"*** ***Correct Date(s) of Service: Change requested effective date from 08/01/2010 to 10/01/2010***	
Add/Change Modifier:	
Correct Number of Service(s):	
Correct Place of Service:	
Correct Diagnosis Code(s):	
Correct Date(s) of Service:	
Correct NPI:	
Other: (Please Explain)	

Comments

NOTE: *The Alabama Medicaid Agency cannot revise a PA for which a claim has already been paid. The paid claim must be voided before the PA can be changed. This form* ***must be received within 90 days*** *of the date of the approval on the PA decision letter.* ***The form is to be used for PA requests in evaluation status or for simple changes to an approved PA, such as adding appropriate modifiers. The form is NOT to be used for reconsiderations of denied PAs; for procedure code changes, or for pharmacy PAs.*** *Please fax completed form to the Alabama Medicaid Agency at (334) 353-9352 or (334) 353-4909. Allow at least 5 business days to process request.*

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E.11 Early Refill DUR Override Request Form

NOTE:

The Pharmacy Override Form 409 may be downloaded from the Medicaid website at www.medicaid.alabama.gov.

E.12 Growth Hormone for AIDS Wasting

NOTE:

PA Form- Growth Hormone-AIDS Wasting, may be downloaded from the Medicaid website at www.medicaid.alabama.gov.

E.13 Growth Hormone for Children Request Form

NOTE:

PA Form – Growth Hormone- Child may be downloaded from the Medicaid website at www.medicaid.alabama.gov.

E.14 Adult Growth Hormone Request Form

NOTE:

PA Form – Growth Hormone – Adult may be downloaded from the Medicaid website at www.medicaid.alabama.gov .

E.15 Maximum Unit Override

NOTE:

The Pharmacy Override Form 409 may be downloaded from the Medicaid website at www.medicaid.alabama.gov .

E.16 Miscellaneous Medicaid Pharmacy PA Request Form

NOTE:

The PA Form for Miscellaneous Drugs may be downloaded from the Medicaid website at www.medicaid.alabama.gov.

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E.17 EPSDT Child Health Medical Record (4 pages)

EPSDT CHILD HEALTH MEDICAL RECORD

Name_____ Medicaid Number _____
Last First Middle

Sex Race
__M ___White ____Black ____Am. Indian Birth Date _____
__F ___Latino ____Asian ____Other

I give permission for the child whose name is on this record to receive services in the _____
I understand that he/she will receive tests, immunizations, and exams. I understand that I will be expected to follow plans that are mutually agreed upon between the health staff and me.

Date_____ Relationship_____ Date_____ Relationship _____
Signature_____ Signature_____
Date_____ Relationship_____ Date_____ Relationship _____
Signature_____ Signature_____
Date_____ Relationship_____ Date_____ Relationship _____
Signature_____ Signature_____
Date_____ Relationship_____ Date_____ Relationship _____
Signature_____ Signature_____

FAMILY HISTORY
(Code Member Having Disease)
(F-Father, M-Mother, S-Sibling, GP-Grandparent,O-Other)
If Negative, place an N in the blank

____ heart disease ____ high blood pressure ____ tuberculosis ____ cancer
____ stroke ____ blood problem/disease ____ birth defects ____ stroke
____ asthma ____ nerve/mental problem ____ mental retardation ____ diabetes
____ alcohol/drug abuse ____ foster care ____ Other

Update (annually)_____ Update (annually)_____
Update (annually)_____ Update (annually)_____
Update (annually)_____ Update (annually)_____
Update (annually)_____ Update (annually)_____

MEDICAL HISTORY

HISTORY	0-Neg +-Pos	DETAIL POSITIVES	HISTORY	0-Neg +-Pos	DETAIL POSITIVES
Childhood Diseases			Frequent Colds		
Diabetes Mellitus			Tonsilitis		
Epilepsy			Bronchitis		
Thyroid Dysfunction			Ear Infection		
Mental I Illness			Pneumonia		
Rheumatic Fever			Convulsions		
Heart Disease			Headache		
Hepatitis			Drug Sensitivity		
Blood Dyscrasia			Allergies		
Anemia			Medications		
Eczema			Operation, Accident		
Tuberculosis			Drug Abuse		
Asthma			Chronic Problems		

Hospitilizations (year & reason)_____

Updates (each screening)_____

Form 172
Revised 1/1/97 Alabama Medicaid Agency

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Page 2

DEVELOPMENTAL ASSESSMENT

DATE	NORMAL	ABNORMAL (detail)	DATE	NORMAL	ABNORMAL (detail)

ANTICIPATORY GUIDANCE

(Should be done at each screening and documented with a date)

2 Weeks to 3 Months_____
Dates completed

_____Nutrition
_____Safety
_____Spitting up, hiccoughs, sneezing, etc.
_____Immunizations
_____Need for affection
_____Skin & scalp care, bathing frequency
_____Teach how to use the thermometer
and when to call the doctor

4 to 6 Months_____
Dates Completed

_____Nutrition
_____Safety
_____Teething & drooling/dental hygiene
_____Fear of strangers
_____Lead poisoning
_____

7 to 12 Months_____
Dates completed

_____Nutrition
_____Safety
_____Dental hygiene
_____Night crying
_____Separation anxiety
_____Need for affection
_____Discipline
_____Lead poisoning
_____

13 to 18 Months_____
Dates completed

_____Nutrition
_____Safety
_____Dental hygeine
_____Temper tantrums
_____Obedience
_____Speech development
_____Lead poisoning
_____Toilet training counseling begins

19 to 24 Months_____
Dates Completed

_____Nutrition
_____Safety
_____Need for peer relationships
_____Sharing
_____Toilet training should be in progress
_____Dental hygeine
_____Need for affection and patience
_____Lead poisoning

3 to 5 Years_____
Dates completed

_____Nutrition
_____Safety
_____Dental hygiene
_____Assertion of independence
_____Need for attention
_____Manners
_____Lead poisoning
_____Alcohol & drugs

6 to 13 Years_____
Dates completed

_____Nutrition
_____Safety (auto passenger safety)
_____Dental care
_____School readiness
_____Onset of sexual awareness
_____Peer relationships (male & female)
_____Parent-child relationships
_____Prepubertal body changes (menst.)
_____Alcohol, drugs and smoking
_____Contraceptive information if sexually active
_____
_____
_____

14 to 21 Years_____
Dates completed

_____Nutrition/dental
_____Safety (automobile)
_____Understanding body anatomy
_____Male-female relationships
_____Contraceptive information
_____Obedience and discipline
_____Parent-child relationships
_____Alcohol, drugs and smoking
_____Occupational guidance
_____Substance abuse
_____
_____
_____

NUTRITIONAL ASSESSMENT

DATE	ADEQUATE	INADEQUATE (detail)	DATE	ADEQUATE	INADEQUATE (detail)

Form 172 Revised 1/1/97 **Alabama Medicaid Agency**
Page 2 of 4

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Page 3

LABORATORY TESTING

	Hematocrit Hemoglobin	Urine Sugar/Albumin	Lead	Sickle Cell Screen	Other
Date					
Results					
Date					
Results					
Date					
Results					
Date					
Results					
Date					
Results					
Date					
Results					
Date					
Results					
Date					
Results					

Date	PROGRESS NOTES	SIGNATURE

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Page 4

PHYSICAL ASSESSMENT

(UC=Under the care)

Date of Exam									
Age	School Grade								
Height	Weight								
Head Circumference									
Temperature									
Pulse	Blood Pressure								
Hearing		(R)	(L)	(R)	(L)	(R)	(L)	(R)	(L)
Vision		(R)	(L)	(R)	(L)	(R)	(L)	(R)	(L)
Dental Care		Referral ___ *UC ___		Referral ___ UC ___		Referral ___ UC ___		Referral ___ UC ___	
Physical Examination		WNL ☐ Abnormal:		WNL ☐ Abnormal:		WNL ☐ Abnormal:		WNL ☐ Abnormal:	
Signature									

PHYSICAL ASSESSMENT

Date of Exam									
Age	School Grade								
Height	Weight								
Head Circumference									
Temperature									
Pulse	Blood Pressure								
Hearing		(R)	(L)	(R)	(L)	(R)	(L)	(R)	(L)
Vision		(R)	(L)	(R)	(L)	(R)	(L)	(R)	(L)
Dental Care		Referral ___ UC ___		Referral ___ UC ___		Referral ___ UC ___		Referral ___ UC ___	
Physical Examination		WNL ☐ Abnormal:		WNL ☐ Abnormal:		WNL ☐ Abnormal:		WNL ☐ Abnormal:	
Signature									

Form 172 Revised 1/1/97 **Alabama Medicaid Agency**
Page 4 of 4

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E.18 Alabama Medicaid Agency Referral Form

ALABAMA MEDICAID REFERRAL FORM
PHI-CONFIDENTIAL

Today's Date _____

Date Referral Begins _____
(if different from above)

Important NPI Information
See Instructions

Medicaid Recipient Information

Recipient Name	Recipient #	Recipient DOB
Address	Telephone # with Area Code _____ Name of Parent/Guardian _____	

Primary Care Provider /Alabama Coordinated Health Care Network Information	Screening Provider (if different from PCP)
Name	Name
Address	Address
Telephone # with Area Code _____ Fax # with Area Code _____ Email _____ NPI # _____ Medicaid Provider # _____ Signature _____	Telephone # with Area Code _____ Fax # with Area Code _____ Email _____ NPI # _____ Medicaid Provider # _____ Signature _____

Type of Referral

☐ PCP/ACHN ☐ EPSDT Screening Date _____ *Select one of the following types of EPSDT Screenings:* ☐ Periodic ☐ Interperiodic ☐ Case Management / Care Coordination	☐ Lock-in ☐ Other (please describe) _____

Length of Referral

Referral valid for _____ month(s) or _____ visit(s) from date referral begins.

Referral Valid For

☐ Evaluation Only	☐ Treatment Only
☐ Evaluation and Treatment	☐ Hospital Care (Outpatient)
☐ Referral by consultant to other provider for identified condition (cascading referral)	☐ Performance of Interperiodic Screening (if necessary)
☐ Referral by consultant to another provider for additional conditions diagnosed by consultant (cascading referral for EPSDT only)	☐ For Billing Purposes Only ☐ Other (please describe) _____

Reason for referral by PCP/ACHN	Other conditions/diagnoses identified by PCP

Consultant Information (Consultant can be an individual provider or a provider group)

Consultant Name	
Address	Consultant Telephone # with Area Code

Note: Please submit written report of findings including the date of examination/service, diagnosis, and consultant signature to PCP

Findings should be submitted to Primary Care Physician (PCP) by

☐ Mail ☐ E-mail ☐ Fax ☐ In addition, please telephone

Form 362
Revised 10/2019

Alabama Medicaid Agency
www.medicaid.alabama.gov

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10/2019

Instructions for Completing
The Alabama Medicaid Referral Form (Form 362)

TODAY'S DATE- Date form completed

REFERRAL DATE- Date referral becomes effective

RECIPIENT INFORMATION- Patient's name, Medicaid number, date of birth, address, telephone number and parent's/guardian's name

PRIMARY CARE PROVIDER (PCP)- Provide all Provider information. For hard copy referrals, the printed, typed, or stamped name of the PCP with an original signature of the physician or designee is required. Stamped or copied signatures will not be accepted. For electronic referrals provider certification is made via standardized electronic signature protocol.

SCREENING PROVIDER- Screening provider (if different from primary provider) must complete and sign if the referral is the result of an EPSDT screening.

NPI INFORMATION- Provide the NPI number of the referring PCP. For billing purposes, indicate Medicaid Provider number, if available.

TYPE OF REFERRAL:

- **PCP/ACHN**- Referral to specialist/consultant. (See *Chapter 40 for Claim Filing Instructions).
- **EPSDT** - Referral resulting from an EPSDT screening. – indicate screening date (See *Appendix A for Claim Filing Instructions)
  Select one of the following types of EPSDT Screenings:
  - **Periodic**- Well-child checkups that are based on a periodicity schedule
  - **Interperiodic**- Problem-focused and abnormal screenings that are medically necessary for undiagnosed conditions outside the periodicity schedule
- **Case Management/Care Coordination** - Referral for case management services through Network Care Coordinators (See *Chapter 40 for ACHN contact information).
- **Lock-In** - Referral for recipients on lock-in status who are locked in to one doctor and/or one pharmacy (See *Chapter 3 -3.3.2 for Claim Filing Instructions).
- **Other** – All other referral types. (Describe referral type)

LENGTH OF REFERRAL- Indicate the number of visits/length of time for which the referral is valid. *(Note: Must be completed for the referral to be valid).*

REFERRAL VALID FOR:

- **Evaluation Only** - Consultant will evaluate and provide findings to PCP.
- **Evaluation and Treatment** - Consultant can evaluate and treat for diagnosis listed on the referral.
- **Referral by consultant to other Provider for identified condition (Cascading Referral)** - After evaluation, consultant may, using PCP's NPI, refer recipient to another specialist as indicated for the condition identified on the referral form without having to get an additional referral from the PCP.
- **Referral by consultant to another Provider for additional conditions diagnosed by consultant (Cascading Referral)** – Consultant may refer recipient to another specialist for other diagnosed conditions without having to get an additional referral from the PCP. **(EPSDT ONLY)**
- **Treatment Only** - Consultant will treat for diagnosis listed on referral.
- **Hospital Care (Outpatient)** - Consultant may provide care in an outpatient setting.
- **Performance of Interperiodic Screening (if necessary)** - Consultant may perform an interperiodic screening if a condition was diagnosed that will require continued care or future follow-up visits.
- **For Billing Purposes Only**—For ACHN Referrals to specialists/consultants when a PCP is not attributed.
- **Other** – All other referral validation types (i.e. DME). (Describe referral validation type)

REASON FOR REFERRAL BY PCP/ACHN- Indicate the reason/condition the recipient is being referred.

OTHER CONDITIONS/DIAGNOSIS IDENTIFIED BY PCP- Indicate any condition present at the time of initial exam by PCP.

CONSULTANT INFORMATION- Consultant's name, address and telephone number. The consultant can be an individual provider or provider group.

PLEASE SUBMIT FINDINGS TO PCP- The PCP should indicate how he/she wants to be notified by the consultant of findings and/or treatment rendered.

*The Alabama Medicaid Provider Manual is available on the Alabama Medicaid website at http://www.medicaid.alabama.gov

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E.19 Psychiatric Residential Treatment Facility Model Attestation Letter
(The facility director must sign this attestation)

(PRTF LETTERHEAD)
NAME OF THE PRTF
ADDRESS
CITY, STATE, ZIP CODE
PHONE NUMBER

Medicaid Provider Number	
Number of Beds in Facility	
Number of individuals currently served in the PRTF who are receiving Alabama Medicaid covered *Psych Under 21* (PRTF) benefits	
Number of individuals, if any, whose PRTF services are being paid for by a state Medicaid agency other than Alabama Medicaid	

Dear (ALABAMA MEDICAID COMMISSIONER):

A reasonable investigation subject to my control having been conducted in the subject facility, I make the following certification. I hereby attest that I have read all of the requirements set out in the regulations as codified at 42 CFR 483.350-483.376. Based upon my personal knowledge and belief, I attest that the (NAME OF FACILITY) hereby complies with all of the requirements set forth in the interim final rule governing the use of restraint and seclusion in psychiatric residential treatment facilities providing inpatient psychiatric services to individuals under age 21 published on January 22, 2001, and amended with the publication of May 22, 2001 (*Psych Under 21 rule*).

I understand that the Centers for Medicare and Medicaid Services (CMS, formerly HCFA), the Alabama Medicaid Agency, or their representatives may rely on this attestation in determining whether the facility is entitled to payment for its services and, pursuant to Medicaid regulations at 42 CFR, Section 431.610, have the right to validate that (NAME OF FACILITY) is in compliance with the requirements set forth in the *Psych Under 21* rule, and to investigate serious occurrences as defined under this rule.

(NAME OF FACILITY) will submit a new attestation of compliance by July 21st of each year (or by the next business day if July 21st falls on a weekend or holiday).

In addition, I will notify the Alabama Medicaid Agency immediately if I vacate this position so that an attestation can be submitted by my successor. I will also notify the Alabama Medicaid Agency if it is my belief that (NAME OF FACILITY) is out of compliance with the requirements set forth in the *Psych Under 21* rule.

Signature_____Title_____

Printed Name_____Date_____

This attestation must be signed by an individual who has the legal authority to obligate the facility.

Revised 02/04/2021
This form can be downloaded from the Alabama Medicaid Agency website: www.medicaid.alabama.gov

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E.20 Certification of Need for Services: Emergency Admission to a Psychiatric Residential Treatment Facility

This form is required for Medicaid recipients under age 21 who are admitted to an Alabama psychiatric residential treatment facility (PRTF) on an emergency basis or for individuals who become eligible for Medicaid after admission to the PRTF. The interdisciplinary team shall complete and sign this form within 14 days of the emergency admission. This form shall be completed on or before the date of the application for Medicaid coverage for individuals who become eligible after admission. This form shall be filed in the recipient's medical record upon completion to verify compliance with the requirements in the Medicaid Administrative Code Rule 560-X-41-.13.

_____

Recipient Name **Recipient Medicaid Number**

_____

Date of Birth **Race** **Sex** **County of Residence**

_____

Facility Name and Address **Admission Date**

INTERDISCIPLINARY TEAM CERTIFICATION:

1. **Ambulatory care resources available in the community do not meet the treatment needs of this recipient.**
2. **Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician.**
3. **The services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will no longer be needed.**

_____

Printed Name of Physician Team Member **Signature** **Date**

_____

Printed Name of Other Team Member **Signature** **Date**

_____

Printed Name of Other Team Member **Signature** **Date**

Form 371 ***Revised 02/04/2021***

This form can be downloaded from the Alabama Medicaid Agency website: ***www.medicaid.alabama.gov***

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E.21 Certification of Need for Services: Non-Emergency Admission to a Psychiatric Residential Treatment Facility

This form is required for Medicaid recipients under age 21 seeking non-emergency admission to an Alabama psychiatric residential treatment facility (PRTF). The independent team shall complete and sign this form not more than 30 days prior to admission. This form shall be filed in the recipient's medical record upon admission to verify compliance with the requirements in the Medicaid Administrative Code Rule 560-X-41-.13.

Recipient Name **Recipient Medicaid Number**

Date of Birth **Race** **Sex** **County of Residence**

Facility Name and Address **Planned Admission Date**

PHYSICIAN CERTIFICATION:

1. I am not employed or reimbursed by the facility.
2. I have competence in diagnosis and treatment of mental illness.
3. I have knowledge of the patient's situation.
4. Ambulatory care resources available in the community do not meet the treatment needs of this recipient.
5. Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician.
6. The services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will no longer be needed.

Printed Name of Physician **Physician Signature** **Phone Number** **Date**

Physician Address **License Number**

Printed Name of Other Team Member **Signature** **Phone Number** **Date**

Printed Name of Other Team Member **Signature** **Phone Number** **Date**

Form 370 *Revised 02/04/2021*
This form can be downloaded from the Alabama Medicaid Agency web site: www.medicaid.state.al.us.

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E.22 PCP Override Request Form

PCP Override Request Form

Please fill out this form **completely** to request a PCP override when you have received a denial for referral services **or** the Primary Care Provider (PCP) has not authorized treatment for **past** date(s) of service. You may also use this form to request an override for a BMI that cannot be obtained. The request must be submitted to Medicaid's Network Provider Assistance Unit within 90 days of the date of service. Attach a **"clean claim"** with any supporting documentation to this form and mail to the Network Provider Assistance Unit at the address below. The Network Provider Assistance Unit will process your request within 60 days of receipt. If your request is approved, the corrected claim will be sent to DXC and will be processed. If your request is denied, Managed Care Operations will notify you by mail of the denial. This form is available in Appendix E of the Alabama Medicaid Provider Manual and at www.medicaid.alabama.gov.

Mail To:
Alabama Medicaid Agency
Network Provider Assistance Unit
501 Dexter Avenue
Montgomery, AL 36103

Recipient's name:_____Medicaid number: _____

Recipient's telephone number: (_____)_____Date(s) of service: _____

Name of PCP:_____PCP's telephone number: (_____)_____

Name of person contacted at PCP's office:_____Date contacted: _____

Reason PCP stated he would not authorize treatment: _____

_____

I am requesting an override due to: **(Please check applicable)**

☐ Recipient not attributed to a PCP
☐ Unable to contact or identify the PCP **Please explain**: _____

_____

☐ Unable to obtain BMI (must submit documentation to support reasoning) **Please explain**: _____

_____

☐ Other **Please explain**: _____

_____

Provider name: _____

NPI #_____

Form completed by: _____

Telephone_____Fax _____

Form 391
Revised 12/2019

Alabama Medicaid Agency
www.medicaid.alabama.gov

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E.23 Request for Administrative Review of Outdated Medicaid Claim

Alabama Medicaid Agency

Request for Administrative Review of Outdated Medicaid Claim

This form is to be completed only if the claim is more than one year old from the date of service.

Section A

Provider's Name:	Provider Number:
Recipient's Name:	Recipient's Medicaid Number:
Date of Service:	ICN:

I do not agree with the determination made on my EOB dated: __/__/____

Section B

Please explain in detail your reasoning that the denial should be over turned and the claim paid:

_____

_____

_____

_____

_____

_____

Section C

Provider or representative's signature:
Provider or representative's signature;
Provider or representative's name:
Address(Street, City, State and Zip):
Date:

Form 404 Rev. 02/26/2016

This form may be downloaded from the Medicaid website at: www.medicaid.alabama.gov

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7.2.1 Administrative Review and Fair Hearings

The Alabama Medicaid Agency is responsible for mandating and enforcing the Title XIX Medical Assistance State Plan. The Alabama Medicaid Agency contracts with a fiscal agent to process and pay all claims by providers of medical care, services, and equipment authorized under the provisions of the Alabama Title XIX State Plan. The present fiscal agent contract is with Hewlett-Packard Enterprise (HPE), PO Box 244032, Montgomery, AL 36124-4032. Their toll free telephone is 800-688-7989.

HPE provides current detailed claims processing procedures in a manual format for all claim types covered by Medicaid services. HPE prepares and distributes the **Alabama Medicaid Agency Provider Manual** to providers of Medicaid services electronically via the Alabama Medicaid Agency website. This manual is for guidance of providers in filing and preparing claims.

Providers with questions about claims should contact HPE. Only unsolved problems or provider dissatisfaction with the response from HPE should be directed to the Alabama Medicaid Agency, 501 Dexter Avenue, Montgomery, Alabama 36104 or by calling 334-242-5000.

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E.24 Prior Authorization Request Form for Durable Medical Equipment

Alabama Medicaid Agency
501 Dexter Avenue
P. O. Box 5624
Montgomery, Alabama 36103-5624

ALABAMA MEDICAID AGENCY
DURABLE MEDICAL EQUIPMENT
☐ Certification ☐ Recertification

Section I: Patient Information -- Complete All Items Pertaining to the Patient's Condition and Equipment

1. Patient's Name	2. Medicaid Number	3. Date of Last EPSDT Screening
4. Indicate all relevant diagnoses		5. Prognosis ☐ Good ☐ Fair ☐ Poor
6. Estimated number of months equipment needed (Do not put "Indefinite." Be specific.) _____	7. Date Prescribed _____	8. Requested HCPC code(s) _____

9. Rental Period this certification applies to
(Certification length CANNOT exceed 12 months)
From _____ To _____
Short Term (6 months or less) _____ (MM-DD-YYYY)
Continuous Rental _____ (MM-DD-YYYY)

10. Supplier's Name _____
Street Address _____
City, State, Zip _____
Telephone # _____
Supplier's Provider Number _____

11. What is The Patient's Condition Concerning Mobility?
a. Bed Confined? ☐ No ☐ Yes - If Yes, complete below
☐ <50% of the time ☐ 50% of the time ☐ 75% of the time ☐ 100% of the time
b. Room Confined? ☐ No ☐ Yes
c. Wheelchair Confined? ☐ No ☐ Yes
d. Ambulatory ☐ No ☐ Yes - If Yes, complete below
☐ Assistance not required ☐ Assisted by a walker or cane ☐ Assisted by a person
e. Is Patient Disoriented? ☐ No ☐ Yes
f. Can patient position self? ☐ No ☐ Yes
g. Does patient have severe contractions? ☐ No ☐ Yes If yes, where? _____
h. Is the patient comatose? ☐ No ☐ Yes
i. Is the patient semi comatose? ☐ No ☐ Yes
j. Is the patient highly susceptible to decubitis ulcers? ☐ No ☐ Yes If yes, explain _____
k. Does patient have decubitis ulcers? ☐ No ☐ Yes If yes, what stage? _____

Section II: General Equipment -- Complete All Applicable Responses

12. General equipment selected for patient (complete all applicable items above in 11)
☐ New Equipment ☐ Replacement Equipment (Attach documentation)

a. Wheelchair
☐ Standard (11a-11k must be completed)
☐ Electric (Form 384 must be completed)
☐ Custom (Form 384 must be completed)
Accessories _____ (Type of Accessory / Weight of Patient / Depth)

b. Hospital Bed ☐ variable ☐ fixed
☐ Semi electric
☐ Other (please specify) _____
Accessories _____ (Type of Accessory / Weight)

c. Hospital Bed Accessories:
Patient has physical and mental capacity to use equipment ☐ Yes ☐ No
Hydraulic lift with: ☐ Seat or ☐ Sling
Trapeze bar ☐ Standard or ☐ Heavy Duty Patient's weight _____
Bed Rail ☐ Yes ☐ No Height _____

d. Ambulatory Devices
☐ Walker ☐ Crutches ☐ Quad Cane ☐ Three pronged cane

Form 342-A
4/2/08

Alabama Medicaid Agency
www.medicaid.alabama.gov

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Section III: Respiratory Equipment -- Complete All Applicable Responses
*** Indicates EPSDT Only**

13. Apnea Monitor *
☐ Apnea ☐ SIDS Sibling Biological (Brother or Sister) ☐ High Risk for Apparent Life Threatening Event (ALTE)
☐ Infant less than 2 years of age with Trach ☐ Preterm infant with period of pathologic apnea

14. Overnight Pulse Oximetry *
☐ Evaluation for serious respiratory diagnosis and requires short term oximetry to rule out hypoxemia or determine the need for supplemental oxygen

15. Pulse Oximetry * - Patient on supplemental oxygen approved by Medicaid and patient has one of the following conditions
☐ Trach ☐ Ventilator dependant ☐ Unstable saturations with weaning in progress

16. Percussor *
Patient has one of following diagnoses
☐ Cystic Fibrosis ☐ Bronchiectasis, and
Failed chest physiotherapy (Attach clinical documentation)
☐ Hand Percussion ☐ Postural drainage Date used _____ through _____ , and
Caregiver ability to perform chest physiotherapy
☐ Caregiver not available to perform physiotherapy ☐ Caregiver not capable of performing physiotherapy

17. Air Vest*
a. Acute Pulmonary exacerbation during last 12 months documented by
☐ Hospitalization ≥ 2, and ☐ Episode of home IV antibiotic therapy, and
b. ☐ FEV1 in one second < 80% of predicted value, or ☐ FVC is < 50% of predicted value, and
c. ☐ Need for chest physiotherapy ≥ 2 times daily, and
d. Documented failure of other forms of chest physiotherapy
(Attach clinical documentation)
☐ Hand percussion ☐ Mechanical percussion ☐ Positive Expiratory Pressure

18. Ventilator (check one) * ☐ Laptop ☐ Volume Ventilator
a Dependent on vent 6 hours or more per day, and ☐ Yes ☐ No
b. Dependent on vent for at least 30 consecutive days, and ☐ Yes ☐ No
(Medical documentation from the recipient's primary physician indicates long term dependency on ventilator support)
c. Would need care in hospital, NF, ICF, MR and eligible inpatient care under state plan, and ☐ Yes ☐ No
d. Patient has social supports to remain in home, and ☐ Yes ☐ No
e. Physician has determined that home vent care is safe, and ☐ Yes ☐ No
f. Patient has at least one or more of the following
☐ Chronic respiratory failure
☐ Spinal cord injury
☐ Chronic pulmonary disorders
☐ Neuromuscular disorders
☐ Other neurological disorders and thoracic restrictive diseases

19. CPAP/BIPAP *
a. Physician ☐ Pulmonologist ☐ Neurologist ☐ Board certified sleep specialist
b. Patient diagnosis of☐ Obstructive sleep apnea ☐ Upper airway resistance syndrome ☐ Mixed sleep apnea
c. Sleep study recorded for ≥ 360 minutes/6 hours ☐ Yes ☐ No
OR
For patients < 6 months old -- sleep study recorded for ≥ 240 minutes/4 hours ☐ Yes ☐ No
d. Sleep study documents
☐ RDI or AHI ≥ 5 per hour ☐ At least 30 apneas/hypopneas found in sleep study
☐ CPAP reduces sleep events by ≥ 50%
For BIPAP only ☐ Unsuccessful trial of CPAP or ☐ Patient is ≤ 5 years

20. Suction Pump -- Patient unable to clear airway of secretions by cough due to one of the following conditions:
☐ Cancer/surgery of throat ☐ Paralysis of swallowing muscles ☐ Other _____
☐ Tracheostomy ☐ Comatose or semi-comatose condition (specify)

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SECTION IV: MEDICAL APPLIANCES AND SUPPLIES

21. Disposable Diapers *

(Patient meets all of following)

- ☐ ≥ 3 years old, and
- ☐ Patient non-ambulatory or minimally ambulatory (cannot walk 10 feet or more without assistance)

Patient at risk for skin breakdown and has at least two of the following:

- ☐ Unable to control bowel or bladder functions
- ☐ Unable to use regular toilet facilities due to medical condition
- ☐ Unable to physically turn or reposition self
- ☐ Unable to transfer self from bed to chair or wheelchair without assistance

---

22. Augmentative Communication Device

- ☐ Patient is mentally, physically and emotionally capable of operating ACD device
- ☐ Medical evaluation completed within 90 days of request for device and patient has a medical condition which impairs the ability to communicate and ACD device is needed to communicate
- ☐ Patient has evaluation by interdisciplinary team which includes a physician, speech pathologist or PT, OT or social worker.
- ☐ Request is for modification or replacement,and one of the following conditions exist
  Include supporting documentation.
  - ☐ Patient had medical change
  - ☐ ACD no longer under warranty, device does not operate to capacity or repair is no longer cost effective
  - ☐ New technology is significantly meets medical need of client that is not meet with current equipment

---

23. Home Phototherapy

- ☐ Infant is term (≥ 37 weeks of gestation) >48 hours of age and otherwise healthy, and
- ☐ Serum bilirubin levels >12, and
- ☐ Elevated bilirubin levels are not due to a primary liver disorder, and
- ☐ Diagnostic evaluation is negative (see instructions), and
- ☐ Infants' age and bilirubin concentration is one of the following
  - ☐ Infant 25-48 hours of age with serum bilirubin ≥ 12 (170)
  - ☐ Infant 49-72 hours of age with serum bilirubin ≥ 15 (260)
  - ☐ Infant great than 72 hours of age with serum bilirubin ≥ 17 (290)

---

24. Alternating Pressure Pad with Pump or Gel or Gel like Pressure Pad for Mattress

- ☐ Patient is bed confined 75 to 100% of the time, and
- ☐ Patient is unable to physically turn or reposition alone, or

- ☐ Patient is medically at risk for skin break down and meets one of the following criteria
  - ☐ Impaired nutritional status defined as BMI ≤ 18.5
  - ☐ Fecal or urinary incontinence
  - ☐ Presence of any stage pressure ulcer on the trunk or pelvis
  - ☐ Compromised circulatory status

  AND
- ☐ Documentation of all of the following;
  - ☐ Recipient/caregiver educated on prevention/management of pressure ulcers
  - ☐ Assessment at least every 30 days by a nurse, doctor or other licensed healthcare professional
  - ☐ Recipient/caregiver can perform appropriate positioning and wound care
  - ☐ Recipient/caregiver understands management of moisture/incontinence
  - ☐ Recipient receives nutritional assessment documenting weight, height, BMI and nutritional intake
  - ☐ Compromised circulatory status

- ☐ Patient is unable to physically turn or reposition alone

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E.25 Request for National Correct Coding Initiative (NCCI) Administrative Review

Alabama Medicaid Agency

Request For National Correct Coding Initiative (NCCI) Administrative Review

This form is to be completed only when the Redetermination Request results in a denial by the Fiscal Agent.

Section A

Print or Type

Provider's Name	Provider Number
Recipient 's Name	Recipient's Medicaid Number
Date of Service	ICN

I do not agree with the Redetermination denial by the Fiscal Agent Dated: _____

Section B

My reasons are:

Section C

Signature of **either** the provider **or** his/her representative

Provider Signature	Representative Signature
Address	Address
City, State and ZIP Code	City, State and ZIP Code
Telephone Number	Telephone Number
Date	Date

This form may be downloaded from the Alabama Medicaid Agency website: www.medicaid.alabama.gov

Form 403
Created 3-21-2011

Alabama Medicaid Agency

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NCCI Administrative Review and Fair Hearings
Alabama Medicaid Provider Manual

Title XIX Medical Assistance State Plan for Alabama Medicaid provides that the Office of the Governor will be responsible for fulfillment of hearing provisions for all matters pertaining to the Medical Assistance Program under the Title XIX. Agency regulations provide an opportunity for a hearing to providers aggrieved by an agency action.

For policy provisions regarding fair hearings, please refer to Chapter 3 of the *Alabama Medicaid Agency Administrative Code*.

When a redetermination request results in a denial by the Fiscal Agent, the provider may request an *NCCI administrative review* of the claim. A request for an NCCI administrative review **must be received by the Medicaid Agency within 60 days of the date of the redetermination denial from the Fiscal Agent**.
In addition to a clean claim, the provider must send a copy of the redetermination denial, all relevant Remittance Advices (RAs) and previous correspondence with the Fiscal Agent or the Agency in order to demonstrate a good faith effort at submitting a claim and supporting documentation. This information will be reviewed and a written reply will be sent to the provider.

Send requests for NCCI Administrative Reviews to the following address:

NCCI Administrative Review
Alabama Medicaid Agency
Attn: System Support Unit
501 Dexter Ave.
P.O. Box 5624
Montgomery, AL 36103-5624

NOTE:
If all NCCI administrative remedies have been exhausted and the claim denies, the provider cannot collect from either the recipient or his/her sponsor or family.

If the NCCI Administrative Review does not result in a favorable decision, the provider may request a fair hearing.

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E.26 Request for NCCI Redetermination Review Form

Request for NCCI Redetermination Review
Gainwell Technologies
PO Box 244032
Montgomery AL 36124-4032

Complete ALL Fields Below - Print or Type

ICN #	**Date of Service**
Recipient Name	**Recipient Medicaid Number**
Provider Name	**Provider NPI Number**
NCCI Denial Code(s) **1.** ☐ **2.** ☐ **3.** ☐	
Date of Denial	

Required Attachments (check box to indicate which attachment is being submitted with request):
Corrected paper claim submitted with procedure code(s) that denied along with specific reports (see below):

- ☐ **Anesthesia report for denied procedure codes in the range: 00100 – 01999**
- ☐ **Operative report for denied procedure codes in the range: 10000 – 69999**
- ☐ **Radiology report for denied procedure codes in the range: 70000 – 79999**
- ☐ **Pathology or Laboratory report for denied procedure codes in the range: 80000 – 89999**
- ☐ **Medical report for denied procedure codes in the range: 90000 – 99605**

Comments:

_____

_____

_____

Signature of either the provider or his/her representative

Date
Address
City, State and Zip code
Telephone Number, including area code
Signature

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E.27 Medicaid Other Insurance Attachment Form

Do not write in this space. Do not use red ink to complete this form.

MEDICAID
OTHER INSURANCE ATTACHMENT

1. Billing Provider ID	a. NPI	**Name**	b.
2. Medicaid ID	a.	**Name**	b.

3. List other payors in order of responsibility. Sequence 1=Primary, 2=Secondary, 3=Tertiary

SEQ	a. HEALTH PLAN ID	b. PAYOR NAME AND ADDRESS	c. POLICY NUMBER	d. DATE PAID
1.				
2.				
3.				

4. Indicate TPL payment amounts per claim detail. (Note: For header amount on Institutional claims use detail number 0.)

a. DTL	b. PAYOR SEQ	c. COPAY	d. COINSURANCE	e. DEDUCTIBLE	f. TPL PAID

Submit completed claim to:

Gainwell
Post Office Box 244032
Montgomery, AL 36124-4032

Form ALTPL-01 10/12

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E.28 Medical Medicaid/Medicare Related Claim Form

Do not write in this space. Do not use red ink to complete this form.

MEDICAL MEDICAID/MEDICARE RELATED CLAIM

1. RECIPIENT INFORMATION

a. Medicaid ID	
b. First Name	
c. Last Name	
d. Med. Rec. #	
e. Patient Acct. # (Optional)	

2. OTHER INSURANCE INFORMATION

a. Covered by other insurance (Except Medicare)? Enter Y if yes or N if no	
b. If other insurance rejected, attach rejection to completed claim and mail to HP and enter date TPL was denied here (MM/DD/YY).	
c. If other insurance paid, attach the completed Medicaid Other Insurance Attachment form (ALTPL01) and mail to HP.	

3. DIAGNOSIS CODES

A._____ B._____ C._____ D._____ E._____ F._____

G._____ H._____ I._____ J._____ K._____ L._____

4. VERSION: 9=ICD-9, 0=ICD-10	

5. DETAIL OF SERVICES PROVIDED

	a. DATES OF SERVICE FROM	THRU	b. POS	c. NDC d. PROCEDURE CODE	e. UNIT	f. MOD	g. DIAG PTR	h. CHARGES	MEDICARE i. ALLOWED	j. COINS.	k. DEDUCTIBLE	l. PAID
1												
2												
3												
4												
5												
6												
7												
8												
9												
						6. TOTALS		a.	b.	c.	d.	e.

It is not necessary to attach Medicare EOMB to this claim unless claim dates of service are over one year old AND Medicare payment is less than 120 days old.

7. Billing Provider Name	a.			
7. Billing Provider ID	b. NPI	c. Taxonomy	d. Qu	e. Secondary ID
8. Performing Provider Name	a.			
8. Performing Provider ID	b. NPI	c. Taxonomy	d. Qu	e. Secondary ID

Submit completed claim to:

HP
Post Office Box 244032
Montgomery, AL 36124-4032

9. Billing Provider mailing address required in block below:

Form 340 Revised 10/12

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E.29 Request for Medical Utilization Redetermination (First Level of Appeal)

Alabama Medicaid Agency

Request for Medical Utilization Redetermination

First Level of Appeal

This form is to be completed only when a claim has been denied for medical utilization. This form is not to be used if a denial of a claim has occurred for being outdated or for NCCI edits. This form is to be sent to the Fiscal Agent. Please print or type information in all areas.

Section A

Provider's Name:	Provider Number:
Recipient's Name:	Recipient's Medicaid Number:
Date of Service:	ICN:

I do not agree with the determination made on my EOB dated: __/__/____

Section B

Please explain in detail your reasoning that the denial should be over turned and the claim paid:

_____

_____

_____

_____

Section C

Provider or representative's signature:
Provider or representative's signature;
Provider or representative's name:
Address(Street, City, State and Zip):
Date:

Form 401 Rev 02/26/2016

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E.30 Request for Medical Utilization Redetermination (Second Level of Appeal)

Alabama Medicaid Agency

Request for Medical Utilization Redetermination

Second Level of Appeal

This form is to be completed only when a claim has been denied for medical utilization. This form is not to be used if a denial of a claim has occurred for being outdated or for NCCI edits. This form is to be sent to the Director of Medical Services at the Alabama Medicaid Agency. Please print or type information in all areas.

Section A

Provider's Name:	Provider Number:
Recipient's Name:	Recipient's Medicaid Number:
Date of Service:	ICN:

I do not agree with the determination made on my EOB dated: __/__/____

Section B

Please explain in detail your reasoning that the denial should be over turned and the claim paid:

_____

_____

_____

_____

Section C

Provider or representative's signature:
Provider or representative's signature:
Provider or representative's name:
Address(Street, City, State and Zip):
Date:

Form 402 Rev 02/26/2016

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F Medicaid Internal Control Numbers (ICN)

Gainwell assigns each claim an Internal Control Number (ICN) systematically when it is received electronically or by mail.

Processing or returning the claim constitutes Gainwell final action on that claim. A resubmission of the same service is considered a new claim.

Each claim sent to Gainwell 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 Gainwell actually received the claim.

Example: 20 21 001 200 001

Region	Year	Julian Date	Batch Range	Sequence

Region

The first two digits in the ICN are the region code, which identifies the source of the claim. In this case, the term *region* refers to the claim's submission method. The following region codes define the claim's media as well.

Region Code	***Where the Claim Originated***
00	All Claim Regions
10	Paper claims with no attachments
11	Paper claim
20	Electronic claims with no attachments
21	Electronic claims with attachments
22	Web claims
25	Pharmacy Point of service claims
30	COBA Crossover
40	Converted Region 05 electronic claims
41	Converted Region 10 tape claims
42	Converted Region 22 cap claims (System Generated)
43	Converted Region 33 special batch claims
44	Converted Region 50 online adjustments
45	Converted Region 51 reversals and mass adjustments
46	Converted Region 52 elect provider adjustments
47	Converted Region 98 paper claims
48	Converted Region 07 managed care claims
50	Adjustments – Non-check related
51	Adjustments – Check related
52	Mass adjustments – Non-check related

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Region Code	*Where the Claim Originated*
53	Mass adjustments – Check related
54	Mass adjustments – Void transaction
55	Mass adjustments – Provider rates
56	Adjustments – Void Non-check related
57	Adjustments – Void Check related
59	POS reversal and internet adjustments
70	Encounters
77	Adjustments - encounters
80	Claims reprocessed by Gainwell Systems Engineers
90	Special projects
91	Batches requiring NCCI review

Year

The next two digits represent the year. For example, 21 is the year 2021.

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

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Julian Date Reference Table - Regular Year

Use this table for years 2021, 2022, 2023, 2025, 2026, 2027, 2029, 2030, 2031, and 2033.

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

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Julian Date Reference Table - Leap Year

Use this table for 2020, 2024, 2028 and 2032.

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)
- Collect and submit medical documentation for medical necessity review by Medicaid medical staff 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.

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Medicaid may issue a travel reimbursement for the cost of fare to recipients who are able to ride public transportation to medical services. Recipients should use public transportation whenever possible. Coordinators should determine that public transportation does not meet the recipient's needs before Medicaid authorizes other modes of transportation.

Recipients who request out-of-state transportation to medical facilities must have a physician send Medicaid a physician's statement that justifies the need for out-of-state services and assures that such services cannot be obtained in-state.

G.1 Benefits and Limitations

This section describes program-specific benefits and limitations. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations. Refer to Chapter 7, Understanding Your Rights and Responsibilities as a Provider, for general criteria on Medical Necessity/ Medically Necessary Care.

This section explains benefits the NET Program offers to eligible recipients and limitations of NET services.

Escorts

An escort is an individual who is not an employee of a NET transporter and whose presence is required to assist a recipient during transport while at the place of treatment. An escort is typically a relative, guardian, or volunteer. Only one escort is covered per recipient in need, and the recipient must prove an identifiable need for the escort.

Medicaid allows escorts for recipients under the age of 21. Escort Services are utilized in-state or out-of-state for recipients over 21 years of age. A recipient age 21 or older that requests an escort must submit a medical certification statement before Medicaid will reimburse the claim. The certification must document that the recipient has a physical or mental disability that would require assistance, such as the following:

- Blindness
- Deafness
- Mental retardation
- Mental illness
- Physical handicap to a degree that personal assistance is necessary

Covered Services

The NET Program may be used for the following medical services:

- Early Periodic Screening, Diagnosis, and Treatment (EPSDT)
- Inpatient hospital care
- Outpatient hospital care
- Physician services
- Diagnostic devices (for example, x-ray and laboratory)

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- Clinic services (family planning, rural health, and community mental health)
- Dental services
- Orthotic and prosthetic services
- Eye care
- Transportation provided by relatives or individuals living in the same household with the Medicaid recipient
- Transportation provided in the Medicaid recipient's vehicle or relative's vehicle

NOTE:

Medicaid reimburses transportation service to a physician’s office through the NET Program only when prior authorized.

NET Resources

NET services include the following resources when the recipient requires medical care and has no other transportation resources. Coordinators must use the most inexpensive mode of transportation that meets the recipient’s needs.

- Automobile (volunteer driver) - Medicaid encourages multiple passenger transportation. Volunteer drivers can be reimbursed for transport from the recipient's home (or place of admission or discharge) and return, unless Medicaid determines paying for additional mileage is the most economical transportation.
- Minibus
- Wheelchair vans - Escorts are allowed for wheelchair vans when prior approved by Medicaid.
- Bus (commercial or city transit) – This service may be provided in-state or out-of-state.
- Airplane transportation
- Train service
- Escort services for minibus, automobile, commercial bus, train, and airplane transportation - Escort services for commercial bus, train, and airplane transportation are reimbursed for the actual cost of the bus, train, or plane ticket.
- Meals and lodging for the recipient and one escort, when required, during overnight travel

Meals and Lodging

When overnight travel is necessary, Medicaid pays for meals and lodging for the recipient and one escort (when authorized). Medicaid must receive receipts or confirmation of expenses before reimbursement can be made. Reimbursement will not exceed $50 per person, per day.

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Non-Covered Services

The NET program does not cover the following services:

- Any travel when the Medicaid recipient is not an occupant of the vehicle, unless that would be the most economical transportation available
- Meals and lodging for volunteer drivers
- The use of supplies such as oxygen and intravenous fluids
- Transportation for any services other than those covered by Medicaid
- Transportation provided after the death of a Medicaid recipient
- Minibus or wheelchair van travel 30 miles outside the state line
- Services for which prior approval is required but is not obtained
- Services that are not medically necessary or that are not provided in compliance with the provision of this chapter

G.2 Frequently Asked Questions

This section is intended to help NET program providers answer questions frequently asked by Medicaid recipients.

What is Non-Emergency Transportation?

Medicaid's NET program is set up to help pay for rides to and from a doctor's office, clinic, or other place for medical care that can be planned ahead of time. This ride can be in a car, bus, or van and can be given by a friend, neighbor, or family member. You can also get a ride on a city bus or from a group in your town or area.

Who can get a ride?

For Medicaid to pay for a ride, the person who is going to the doctor or clinic must be covered by Medicaid for the visit they are going to make and should be approved for the ride ahead of time.

How does the program work?

For Medicaid to pay for a ride, you (or someone who is helping you) will need to call Medicaid's toll-free number at 1-800-362-1504. When you call, the operator will ask you for some information to make sure you are covered by Medicaid and also about your need for a ride. This information will be used to decide if Medicaid can pay for your ride. The NET hotline is open from 8:00 a.m. to 4:00 p.m., Monday through Friday, except on state holidays.

What do I do?

You must first try to get a ride on your own. If you are approved for a ride, you will be told about people or groups in your areas who can help you get a ride for little or no cost.

If the people or groups in your community who usually give you a ride cannot give you a ride, then call the toll-free hotline to speak to an operator. The operator will try to help you. In some cases, a special Medicaid worker may work with you if you have to go for a lot of medical care or treatment (like kidney dialysis or cancer treatments).

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What if I have an emergency?

If you have an emergency, call 911 (or the emergency number in your town) to reach an ambulance or paramedics who can help you. Medicaid covers ambulance rides when there is an emergency, such as when someone stops breathing or has been badly hurt.

What do I do if I have a medical problem that can't wait?

A medical problem that must be treated right away, but does not cause your life to be in danger is called an "urgent" medical problem. Broken arms, a bad cut, a baby with a bad earache, or mild chest pains are examples of "urgent" problems.

If you have to pay someone to take you to the emergency room or doctor's office after hours because of an "urgent" problem, you need to call Medicaid's toll-free hotline as soon as possible after the visit to apply for payment. Medicaid pays for the ride to the emergency room only if the visit is for an "urgent" medical problem. Medicaid does not pay for a ride to the emergency room for a problem that can wait until the doctor's office or clinic is open.

How much will Medicaid pay for a ride?

Medicaid pays what is reasonable and necessary to make sure you get the medical care you need. If you have questions about this, ask your operator when you call the toll-free number.

What do I do if I have to pay for a ride to see the doctor on the weekend?

Call the toll-free number the next working day after the ride. Tell the operator where you went for care and why you need help in paying for your ride. Depending on what happened, you might be able to get payment for a ride you had to pay for.

Will Medicaid pay for someone to go with me?

Medicaid pays for an escort for a child or for an adult who is unable to go alone because of a physical or mental disability.

How many rides will Medicaid pay for?

Medicaid pays for rides only to a doctor or clinic for medical care or treatment that is covered by Medicaid. For example, once you use up all of your doctor visits for the year, Medicaid will not pay for rides to any doctor visits.

How will Medicaid pay for my ride?

If your ride is approved, Medicaid will send your reimbursement through an Electronic Benefit Transfer (EBT). Once your transportation request to a Medicaid covered service/provider has been verified by a NET worker, your reimbursement will be loaded to an EBT (plastic) card. The EBT card can only be used at stores that display the Quest logo for cash withdrawal or cash purchase transactions.

If you have been approved for transportation reimbursements, an EBT card personalized with your information, along with a training brochure with detailed information on how to use the system, will be mailed to you. The EBT card must be PIN activated **before** it can be used to make cash withdrawals or cash purchases.

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Alabama Medicaid Glossary of Terms

A

ACA	Affordable Care Act
ACHN	Alabama Coordinated Health Network (ACHN)
ACSW	Academy of Certified Social Workers
ADA	Americans with Disabilities Act, also American Dental Association
ADM	Alcohol, drug or mental disorder
ADS	Alternative delivery system
AEAC	Alabama Estimated Acquisition Cost
AEIS	Alabama's Early Intervention System
AEVCS	Automated Eligibility Verification and Claims Submission System
AFDC	Aid to Families with Dependent Children
AHA	American Hospital Association
AHC	Alternative health care
AMA	American Medical Association
ARC	Adjustment Reason Code
AWP	Average wholesale price
Absent Parent	A parent who is responsible for child's medical payments that Medicaid locates. Used in Third Party Liability.
Access	A patient's ability to obtain medical care. The ease of access is determined by components such as the availability of medical services and their accessibility to the patient, the location of health care facilities, transportation, hours of operation and cost of care.
Accounts Payable	Money that Medicaid should pay out
Accounts Receivable	Money owed to Medicaid
Adjudication	The process of determining whether a claim (credit or adjustment) is to be paid
Adjustment Reason Code	Codes used to explain the basis for a denial, reduction, or increase in payment for a service.
Adjustments	Changes made on a paid claim to correct an input or payment error. Adjusted claims receive a new internal claim number that begins with 50 and references the original claim.
Administrative costs	The costs incurred by a carrier such as an insurance company or HMO for administrative services such as claims processing, billing and enrollment, and overhead costs. Administrative costs can be expressed as a percentage of premiums or on a per member per month basis.
Admits	The number of admissions to a hospital or inpatient facility
Alabama Estimated Acquisition Cost	The Average Acquisition Cost (AAC) of a drug or, in cases where no AAC is available, the Wholesale Acquisition Cost (WAC) + 9.2%.

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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.

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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

CAQH CORE	Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE)
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
COB	Coordination of benefits
COBRA	Consolidated Omnibus Budget Reconciliation Act

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CPT (Current Procedural Terminology) Code	Code used to determine procedures on claim forms, taken from the CPT - 4 Manual, an American Medical Association (AMA) approved listing of medical terms and identifying codes for reporting medical services and procedures performed by providers
Calendar year	The period of time from January 1 of any year through December 31 of the same year, inclusive. Most often used in connection with deductible amount provisions of major medical plans providing benefits for expenses incurred within the calendar year. Also found in provisions outlining benefits in basic hospital, surgical, and medical plans.
Capitation	Method of payment for health services in which a physician or hospital is paid a fixed amount for each enrollee regardless of the actual number or nature of services provided to each person. The term usually refers to a negotiated per capita rate to be paid periodically, usually monthly to a health care provider. The provider is responsible for delivering or arranging for the delivery of all health services required by the covered person under the conditions of the provider contract.
Capitation rates	Payment for health services in which a physician or hospital is paid a fixed amount for each enrollee regardless of the actual number or nature of services provided to each person
Carrier	The CMS-designated statewide or regional contractor responsible for Medicare Part B claims administration. Also used generically to refer to private third party payers.
Case management	Planned approach to manage service or treatment to an individual with a serious medical problem. Its dual goal is to contain costs and promote more effective intervention to meet patient needs. Often referred to as large case management. Nurses are often case managers.
Case manager	An experienced professional (such as a nurse, doctor or social worker) who works with patients, providers and insurers to coordinate all services deemed necessary to provide the patient with a plan of medically necessary and appropriate health
Chronic Stable Medical Condition	A condition that has persisted over six months and clinical documentation supports that there has been no significant changes in the past 60 days or in the 60 day period prior to admission.
Civilian Health and Medical Program of Uniformed Services.	The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) is a federal program providing cost-sharing health benefits for dependents and survivors of active duty personnel and for retirees and their dependents and survivors
Claim	A request for payment for services rendered on a standardized form or electronic record
Claims	Demands to the insurer by or on behalf of an insured person for the payment of benefits under a policy. Information submitted by a provider or a covered person to establish that medical services were provided to a covered person from which processing for payment to the provider or covered person is made. The term generally refers to the liability for health care services received by covered persons.
CMS	Center for Medicare and Medicaid services

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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

DHCP	Delivering Healthcare Professional
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 Gainwell pharmacist when updates to DUR criteria are necessary.

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Date of Service	The date on which health care services were provided to the covered person
Deductible	Amount of covered expenses that must be incurred and paid by an insured person before benefits become payable by the insurer
Deferred compensation administrator (DCA)	A company that provides services through retirement planning administration, third party administration, self-insured plans, compensation planning, salary survey administration and workers compensation claims administration
Denial of payment	When services are deemed to be inappropriate, unnecessary, or of poor quality, payment may be denied. The insurer or payer will not pay for services that do not conform to benefit standards.
Dependent	An individual who relies on an employee for support or obtains health coverage through a spouse, parent or grandparent who is the covered person. See also eligible dependent and member.
Diagnosis	The identification of a disease or condition through analysis and examination
Diagnosis-related group (DRG)	System of determining specific reimbursement fees based on the medical diagnosis of a patient. System of classification for inpatient hospital services based on principal diagnosis, secondary diagnosis, surgical procedures, age, sex and presence of complications. This system of classification is used as a financing mechanism to reimburse hospital and selected other providers for services rendered.
Disability	Any condition that results in function limitations that interferes with an individual's ability to perform their customary work and which results in substantial limitation in one or more major life activities
Dispensing Fees	Fees set, and periodically reviewed for fairness, by Medicaid. These fees are set considering such factors as inflation and fee studies or surveys. When deemed appropriate by Medicaid, these fees may be adjusted.
Dual diagnosis	Coexistence of more than one disorder in an individual patient. Commonly refers to a patient who is diagnosed with mental illness in conjunction with substance abuse.
Durable Medical Equipment (DME)	Medical equipment that • can withstand repeated use • generally is not useful to a person in the absence of an illness or injury • generally is not useful to a person in the absence of an illness or injury • is appropriate for use in the home Examples of durable medical equipment include hospital beds, wheelchairs and oxygen equipment.

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E

ECS	Electronic Claims Submission
EFT	Electronic funds transfer
EOB (Explanation of Benefits) Code	Code(s) appearing on the provider's EOP to let them know what action is taken on claims
EOMB	Explanation of Medicare benefits
EOP	Explanation of payment
EOP Message	Message appearing on the top of the remittance advice mailed to providers to address issues and provide information
EPSDT	Early Periodic Screening, Diagnosis, and Treatment
EPSDT (Early and Periodic Screening Diagnosis and Treatment)	Medicaid program for children (until age 21), covering any medically necessary service allowable under Medicaid regulations
Edit	A system run data verification. When the system processes a claim, it runs edits to verify that data on the claim is correct. Examples of edits include: • Match of RID and recipient name • Match of provider name and number
Electronic Claims Submission	A form of electronic submission of claims for services rendered. ECS is the most efficient and effective means of processing claims, ensuring swift adjudication and payment to providers.
Eligibility date	The defined date a covered person becomes eligible for benefits under an existing contract

F

FFS	Fee for service
FQHC	Federally Qualified Health Clinic
Fee-for-service	Method of payment for provider services based on each visit or service rendered
Fee-for-service reimbursement	The traditional health care payment system, under which physicians and other providers receive a payment based on billed charges for each service provided
Frequency	The number of times a service was provided

G

GUI	Graphical user interface
Gainwell Technologies	The fiscal agent for the Medicaid program
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.

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Generic drug	A generic drug is one that has the identical makeup as a brand name drug. A generic is typically less expensive and sold under a common or "generic" name for that drug; for instance, the brand name for one tranquilizer is Valium, but it is also available under the generic name diazepam). Also called generic equivalent.
Generic equivalent	See generic drug.
Generic substitution	Dispensing a generic drug in place of a brand name medication. Substitution guidelines are defined by state regulations.
Graphical user interface (GUI)	The visual interface that characterizes Microsoft Windows and the Macintosh.
Group Practice	Medical practice in which several physicians render and bill for services under a single provider number

H

HCFA	Health Care Financing Administration
HCFA Common Procedural Coding System (HCPCS)	A listing of services, procedures and supplies offered by physicians and other providers. HCPCS include CPT (Current Procedural Terminology) codes, national alphanumeric codes and local alphanumeric codes. The national codes are developed by HCFA to supplement CPT codes. They include physician services not included in CPT as well as non-physician services such as ambulance, physical therapy, and durable medical equipment. The local codes are developed by local Medicare carriers in order to supplement the national codes. HCPCS codes are 5-digit codes, the first digit is a letter followed by four numbers. HCPCS codes beginning with A through V are national; those beginning with W through Z are local.
HCPCS	HCFA Common Procedural Coding System
HHA	Home health agency
HHS	Department of Health and Human Services
HID	Health Information Designs
HIC	Health Insurance Claim Number
HIPC	Health insurance purchasing cooperative
HIPAA	Health Insurance Portability and Accountability Act
HMO	Health maintenance organization
Health Care Financing Administration(HCFA)	A branch of the U.S. Department of Health and Human Services charged with oversight and financial management of government-related health care programs such as Medicare and Medicaid
Health Care Quality Improvement Act	This Act requires health care provider organizations and insurers to report malpractice cases that have been settled or lost. Created in 1986, malpractice suits and other related reference checks can be obtained through the National Practitioner Data Bank.
Health Information Designs (HID)	Organization that provides prior authorization for drugs requiring prior approval

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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.
ICD-10-CM	International Classification of Disease, Tenth Edition, Clinical Modification. A listing used by providers in coding diagnosis on claims.
ICF	Intermediate care facility
IDT	Interdisciplinary team
ICN (Internal Control Number)	The number assigned to each Medicaid claim that allows tracking in the system. The ICN indicates when the claim was received and whether it was sent by paper or electronic media.
IFSP	Individualized Family Service Plan
Impairment	Any loss or abnormality of psychological, physiological, or anatomical structure or function such as hearing loss
Inpatient	An individual who has been admitted to a hospital as a registered bed patient and is receiving services under the direction of a physician for at least 24 hours
Intermediate care facility (ICF)	A facility providing a level of care that is less than the degree of care and treatment that a hospital or skilled nursing facility (SNF) is designed to provide, but greater than the level of room and board

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International classification of diseases	The International classification of diseases, 9th Edition (Clinical Modification) (ICD-9-CM) is a listing of diagnoses and identifying codes used by physicians for reporting diagnoses of health plan enrollees. The coding and terminology provide a uniform language that can accurately designate primary and secondary diagnoses and provide for reliable, consistent communication on claim forms.
Julian Date	Chronological date of the year, 001 through 365 or 366, preceded by a two-digit year designation. Example: 93321 is the 321st day of the 93rd year

K/L

LCSW	Licensed clinical social worker
Local Code(s)	A generic term for code values that are defined for a state or other political subdivision, or for a specific payer.
Lock-in	The term used to describe the status of a recipient who may be potentially overusing or misusing Medicaid services and benefits. The recipient is locked in to one physician and/or pharmacy to receive services.
LOS	Length of stay
Length of stay (LOS)	The number of days that a covered person stayed in an inpatient facility
Long Term Care Facility	A nursing facility that provides 24-hour nursing care
Long Term Care	Care that must be provided over a long period of time. Elderly people tend to need long-term care. Nursing home care is a type of long-term care. The goal of Long Term Care is to help people with disabilities be as independent as possible. A person who requires help with the activities of daily living (ADLs) or who suffers from cognitive impairment needs long Term Care.

M

MAC	Maximum allowable cost
MH/CD	Mental health/chemical dependent
MH/SA	Mental health/substance abuse
MMIS	Medicaid Management Information Systems
MSW	Masters in social work
Managed care	The coordination of financing and provision of health care to produce high quality health care for the lowest possible cost
Medicaid	A state-run program, with matching federal funds, for public assistance to persons, regardless of age, whose income and resources are insufficient to pay for health care
Medicaid eligible	Recipients in the Alabama Medicaid program. Medicaid reimburses for services rendered while the recipient is eligible for Medicaid benefits.
Medical necessity	Refer to Chapter 7, Understanding Your Rights and Responsibilities as a Provider for general criteria on Medical Necessity/ Medically Necessary Care.

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Medical supplies	Items which, due to their therapeutic or diagnostic characteristics are essential in carrying out the care which the physician has ordered for the treatment of the patient's illness or injury. Examples of medical supplies are catheters, needles, syringes, surgical dressings and materials used for dressings, irrigating solutions and intravenous fluids.
Medicare	Federally sponsored program under the Social Security Act that provides hospital benefits, supplementary medical care, and catastrophic coverage to persons age 65 years and older. Includes some younger people who are covered under social security benefits. Medicare covers two parts: Medicare Part A-Covers hospitalization and inpatient costs. Medicare Part B-Covers physician services, ancillary services and outpatient costs.
Mental Health provider	A psychiatrist, licensed consulting psychiatrist, social worker, hospital or other facility duly licensed and qualified to provide mental health services under the law or jurisdiction in which treatment is received
Mental health services	Behavioral health care services that may be provided on an inpatient, outpatient, or partial hospitalization basis
Morbidity	An actuarial determination of the incidence and severity of sicknesses and accidents in a well-defined class or classes of persons

N

NCPDP	National Council of Prescription Drug Programs
NDC	National Drug Code
NHIC	National Heritage Insurance Company
National Council for Prescription Drug Programs Standards	Pharmacy claim telecommunications standards that dictate the order and content of the fields relayed to the pharmacist when the system generates a DUR alert
National drug code (NDC)	A national classification for identification of drugs. Similar to the Universal Product Code (UPC).
National Provider Identifier (NPI)	A 10-digit identification number for healthcare providers.
Non-participating provider (non-par)	A term used to describe a provider that has not contracted with the carrier or health plan to be a participating provider of health care
Noncovered Services	(1) Services not medically necessary; (2) Services provided for the personal convenience of the client; or (3) Services not covered under the Medicaid Program.
Non-emergency Transportation (NET) Program	Program that provides necessary non-ambulance transportation services to Medicaid recipients

O

OBRA 90	Federal law directing how federal monies are to be expended
OLTP	On-line transaction processing
OSCAR	Online Survey Certification and Reporting
OSHA	Occupational Safety and Health Administration

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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 Gainwell 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
PACE	Program of All-Inclusive Care for the Elderly
PCCM	Primary Care Case Management
PCP	Primary Care Physician
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 post payment.

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Peer review organization(PRO)	An entity established by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) to review quality of care and appropriateness of admissions, readmissions and discharges for Medicare and Medicaid. These organizations are held responsible for maintaining and lowering admission rates and reducing lengths of stay while insuring against inadequate treatment. Also known as professional standards review organization.
Per diem	Literally, per day. Term that is applied to determining costs for a day of care and is an average that does not reflect true cost for each patient.
Pharmaceutical services	Pharmacy management programs help to monitor and control the utilization and cost of prescription drugs. These programs also help with the collection and interpretation of information about the prescribing habits of physicians.
Pharmacy and Therapeutics Committee	An organized panel of physicians from varying practice specialties, who function as an advisory panel to the plan regarding the safe and effective use of prescription medications. Often comprises the official organizational line of communication between the medical and pharmacy components of the health plan. A major function of such a committee is to develop, manage, and administer a drug formulary.
Physician	Any doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who is duly licensed and qualified under the law of jurisdiction in which treatment is received or as defined in the summary plan description
Physician's Current Procedural Terminology	A list of medical services and procedures performed by physicians and other providers. Each service and/or procedure is identified by its own unique 5-digit code. CPT has become the health care industry's standard for reporting of physician procedures and services, thereby providing an effective method of nationwide communication.
Place of service	The location where health services are rendered, such as office, home, or hospital
PMPM	Per member per month
Point of sale (POS) device	Enables the real time electronic transfer of information between two places; the user keys information into the POS device and perhaps swipes a card with a magnetic strip through the device
Prescription medication	A drug which has been approved by the Food and Drug Administration and which can, under federal or state law, be dispensed only pursuant to a prescription order from a duly licensed physician
Prevailing charges	Amounts charged by health care providers that are consistent with charges from similar providers for identical or similar services in a given locale
Preventive care	Comprehensive care emphasizing priorities for prevention, early detection and early treatment of conditions, generally including routine physical examination, immunization, and well person care
Preventive services	Wellness and health promotion services that are part of the basic benefits package of a managed health care plan

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Primary Medical Provider (PMP)	Primary deliverers and managers of health care, central to providing appropriate health care. The PMP provides basis care to the enrollee, initiates referrals to specialists, and provides follow-up care. Usually defined as a physician practicing in such areas as internal medicine, family practice, and pediatrics, although an obstetrician/gynecologist may be considered a primary medical physician.
Principal diagnosis	The condition established after study to be mainly responsible for the patient's need for health care services from a provider. Commonly refers to the condition most responsible for a patient's admission to the hospital.
Prior Authorization	Approval provided by Medicaid for specified services for a specific recipient to a specific provider, or the process of obtaining prior approval as to the appropriateness of the service or medication. Prior authorization does not guarantee coverage.
Private Duty Nurse	Service covered by Medicaid that provides hourly nursing care in a home setting
Prospective DUR	Required at the point of sale or distribution before each prescription is filled or delivered to a Medicaid recipient. It must include the screening, patient counseling, and patient profiles.
Provider	Any health care professional enrolled with the Medicaid agency who provides or is eligible to provide a covered service to a Medicaid recipient
Provider Assistance Center (PAC)	This center answers your questions about claim status, eligibility, or other claims-related issues
Provider networks	Groups of physicians, or hospitals, who provide health care to enrollees. Some large employers are establishing their own provider networks to ensure their employees a choice.
Provider	A physician, hospital, group practice, nursing home, pharmacy, or any individual group of individuals that provides a health care service
Providers	Medical professionals and service organizations that provide health care services

Q/R

QA	Quality assurance
QMB	Qualified Medicare beneficiary
Qualified Medicare beneficiary (QMB)	A Part A Medicare beneficiary whose verified income does not exceed certain levels. Income may not exceed 100 percent of the federal poverty level plus $20.
Quality assurance (QA)	A set of activities that measures the characteristics of health care services and may include corrective measures
Remittance Advice Code (RAC)	National code set for providing either claim-level or service-level related messages that cannot be expressed with a Claim Adjustment Reason Code. This code set is used in the X12 835 Claim Payment & Remittance Advice EDI transaction.
R&C	Reasonable and customary
Recipient	Person eligible to receive Medicaid covered services

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Recipient Aid Categories	Categories assigned to a recipient used to assign benefits
Recipient Identification Number (RID)	A unique 13-digit number that identifies a Medicaid recipient
Recoupments	Reduction or adjustment of the amounts paid to a provider on pending and subsequently submitted bills to offset overpayments previously made to the provider. Also, payment made directly to Medicaid by a provider as a settlement for overpayment.
Referral	Primary care provider-directed transfer of a patient to a specialty physician or specialty care
Referral provider	A provider that renders a service to a patient who has been sent to the referral provider by a participating provider in the health plan
Remittance Advice	Notice advising Medicaid providers on claim status (paid, denied, returned, or suspended). This is available on the provider web portal after each checkwrite.

S

SNF	Skilled nursing facility
SSI	Social Security Income
Skilled nursing facilities	Institution providing the degree of medical care required from, or under the supervision of, a registered nurse or physician
Social Security Act	Law under which the federal government operates the Old Age, Survivors, Disability, and Health Insurance Program (OSDHI). Includes Medicare and Medicaid.
Specialty	Specialized area of practice for a provider
Specialty HMOs	Those group practices and organizations of providers who contract with managed care organizations to provide non-primary care medical services
Specialty services	Services that are outside of the realm of general practice
Subrogation	A procedure under which an insurance company can recover from third parties the full or some proportionate part of benefits paid to an insured. For example, should a claim and who has received benefits under a state's statutory plan covering disability benefits enter into litigation to make claims against a third parts, the insurance carrier has a right to place a lien against any benefit the third action party may provide.
Suspend	A claim status in which the claim must be reviewed. Claim type needing in-depth investigation to allow Gainwell adjudicators and provider relations team members to work together to resolve the claim.

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T

TPL	Third party liability
Third Party Liability (TPL)	A condition whereby a person or an organization other than the recipient or Medicaid is responsible for all, or some portion of the medical costs for health or medical services incurred by a Medicaid recipient (health or casualty insurance company, or another person in the case of an accident)
Third-party payer	A public or private organization that pays for or underwrites coverage for health care expenses of another entity, usually an employer. Examples of third-party payers are Blue Cross, Blue Shield, and Medicare.
Transaction	Exchange of information between two parties to carry out financial and administrative activities related to health care. Examples include health claims, health care payment, coordination of benefits, health claim status, enrollment or disenrollment, referrals, etc

U

U&C	Usual and customary
UB04	The common claim form used by hospitals to bill for services. Some managed care plans demand greater detail than is available on the UB-04, requiring the hospitals to send additional itemized bills. The UB-04 replaced the UB-92 in 2008.
UCR	Usual, customary, and reasonable charge
UR	Utilization review
Underutilization	Underutilization is providing fewer services than are necessary for adequate levels of care
Uniform Billing Code of 1992 (UB-92)	A revised version of the UB-82, a federal directive requiring a hospital to follow specific billing procedures, itemizing all services included and billed for on each invoice, which was implemented October 1, 1993.
Unstable Medical Condition (Long Term Care Admission Criteria)	One in which there is documentation of an episode of acute illness or exacerbation of a diagnosis which requires active treatment in the 60 days prior to the admission date. The provider must have supporting documentation of the acute illness or exacerbation and active treatment.
Usual and Customary Charges	Amount which a provider usually and most frequently charges patients for a specific service in normal medical circumstances
Usual, customary and reasonable (UCR)	See reasonable and customary
Usual, customary, and reasonable fees (UCR)	Charges of health care providers that is consistent with charges from similar providers for identical or similar services in a given locale.
Utilization Control Procedures	These procedures safeguard against unnecessary care and services (both under and over utilization), monitor quality, and ensure payments are appropriate according to the payment standards defined by Medicaid.

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Utilization Review (UR)	Programs designed to reduce unnecessary medical services, both inpatient and out. URs may be prospective, retrospective, concurrent, or in relation to discharge planning.

V/W

Vaccines for Children (VCF)	Program that offers free vaccines to qualified health care providers for children 18 years of age and under who are Medicaid eligible, American Indian or Alaskan Native, uninsured, or under insured
Value Added Networks (VANs)	Networks that provide billing services on behalf of an Alabama Medicaid provider
Waiver	Term usually associated with the Medicare or Medicaid programs by which the government waives certain regulations or rules for a managed care or insurance program to operate in a certain geographic area.

X/Y/Z

X12	An ANSI-accredited group that defines EDI standards for many American industries, including health care insurance. Most of the electronic transaction standards proposed under HIPAA are X12 standards
X12 270	X12's Health Care Eligibility & Benefit Inquiry EDI transaction
X12 271	X12's Health Care Eligibility & Benefit Response EDI transaction
X12 276	X12's Health Care Claims Status Inquiry EDI transaction
X12 277	X12's Health Care Claim Status Response EDI transaction
X12 834	X12's Benefit Enrollment & Maintenance EDI transaction
X12 820	X12's Payment Order & Remittance Advice EDI transaction
X12 835	X12's Health Care Claim Payment & Remittance Advice EDI transaction
X12 278	The X12 Referral Certification and Authorization transaction
X12 837	The X12 Health Care Claim or Encounter transaction. This transaction can be used for institutional, professional, dental, or drug claims

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H Alabama Medicaid Physician Administered Drugs

Effective October 1, 2010, the NDC is required on all physician-administered drugs in J, S, and Q code ranges. Physician-administered drugs include any covered outpatient drug billed either electronically or on paper CMS-1500 or UB-04 claim forms.

H.1 Policy

H.1.1 Injections

Medicaid covers physician administered drugs when billed by a physician using the new list of approved HCPCS codes.

The HCPCs drug codes are intended for use in Physician office and Outpatient billing of manufactured medications given in each respective place of service. The Alabama Medicaid Agency only reimburses for compounded medications by the billing of NDC numbers through the Pharmacy Program directives.

Appropriate administration code(s) in the Current Procedural Terminology (CPT) may be billed in addition to the HCPCS drug codes and office visit codes for the same date of service. Please refer to the following section "Evaluation and Management Codes Billed in Conjuction With Drug Administration Codes" for details concerning office visits, chemotherapy administration, hydration therapy and chemotherapy, and date specific changes.

Pricing of Physician Administered Drugs

For Dates of Service prior to July 1, 2005, physician drug prices were updated semi-annually by Gainwell. Medicaid reimbursement was calculated by averaging the Average Wholesale Prices (AWP) from the *Red Book or 80-95% of DIMA (Drug, Improvement, and Modernization Act).*

Effective for Dates of Service July 1, 2005 and thereafter, the Alabama Medicaid Agency adopted Medicare's Drug Pricing Methodology using the Average Sale Price (ASP) for HCPCS injectable drug codes.

Compound Drugs for Non-Pharmacy Providers

The compound drug must not be commercially available, and the active ingredient of the compound drug must follow coverage policy of drugs (FDA approved, non-DESI, not obsolete, etc.).

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When a provider administers a drug that must be purchased from a compounding pharmacy because it is no longer commercially available (e.g. due to the manufacturer no longer marketing the product), the applicable claim form may be submitted for consideration of payment. The billed amount should represent the lesser of the actual acquisition cost for the drug or Medicaid rate on file (ASP CMS pricing) at the time of service.

When billing the HCPCS code for a purchased compounded drug, only one NDC can be used per procedure code. Providers must use the HCPCS procedure code, billing units and corresponding covered NDC number on the claim form; for example, J1100 Injection, dexamethasone sodium phosphate, 1 mg. The NDC billed should be the one that represents the drug as described in the HCPCS code definition, in this case dexamethasone sodium phosphate. See the section entitled "Calculation of Billing Units and Wastage" for information on calculating billing units.

The Agency does not reimburse providers for prescription compounding time or non-covered ingredients used in the compounding process.

Mandatory National Drug Codes (NDC) for ALL Physician Administered Drugs

In compliance with the Deficit Reduction Act (DRA) of 2005, Alabama Medicaid (AMA) began accepting and later began requiring the NDC number for the top 20+ physician-administered multiple source drugs. Information on this requirement may be found in the July 2008 and April 2009 issues of the Provider Insider on the Agency's website.

Effective October 1, 2010, the NDC number became mandatory on **ALL** physician-administered drugs in the following ranges: J0000 – J9999, S0000 – S9999, and Q0000 – Q9999. Physician-administered drugs include any covered outpatient drug billed either electronically or on a paper CMS-1500 or UB-04 claim forms. This is for both straight Medicaid and Medicare/Medicaid crossover claims. The 11-digit NDC submitted must be the actual NDC number on the package or container from which the medicine was administered. The NDC is a number that identifies a prescription drug.

Medicaid provided a **grace period from August 15, 2010 to September 30, 2010**, to allow providers sufficient time to acclimate to the change. During this grace period, Medicaid validated the data and set informational denial codes, but DID NOT deny the claim.

This requirement applies to:

- All fee-for-service providers who bill physician-administered drug codes
- HCPCS codes in the ranges J0000 – J9999, S0000 – S9999, and Q0000 – Q9999.
- Both electronic and paper submissions

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This requirement does **NOT** apply to:

- 340B Providers enrolled on the HHS website
- Vaccines or other drugs in the CPT code ranges 01000 – 99999.
- HCPCS that do not have an NDC
- HCPCS that are considered devices
- HCPCS that are considered radiopharmaceuticals
- Providers paid on a per diem, encounter, or other type of rate, which includes, but may not be limited to:

    - Inpatient Hospitals
    - Nursing Facilities
    - Federally Qualified Health Centers
    - Rural Health Centers
    - Ambulatory Surgical Centers
    - Home Health Agencies

To identify if a product is a drug, look for these three items:

1. NDC - Number located on the package or container of the drug
2. Lot and Expiration Date - All drugs have both a lot number and expiration date on the vial or container
3. Legend - This refers to statements such as, “Caution; Federal law prohibits dispensing without prescription, “Rx only” or similar words. All prescription drugs have these types of statements

As this process is to facilitate Medicaid drug rebates from manufactures for physician-administered drugs, providers are required to utilize drugs manufactured by companies who hold a federal rebate agreement. These NDCs will be the only ones Medicaid will cover for payment. A link to a list of those drug manufacturers who hold a federal rebate agreement, as well as their labeler codes (the first 5 digits of the NDC number), are available on the Medicaid website at: https://medicaid.alabama.gov/content/4.0_Programs/4.3_Pharmacy-DME/4.3.2_Billing_Policy_Info.aspx. Select the “covered labelers (manufacturers) available from CMS” link.

The Alabama Medicaid Agency implemented a Drug Lookup System effective October 5, 2010. The system allows non-pharmacy providers needing NDC information for the billing of HCPCS codes to search for drugs by drug name or NDC and will display coverage information. Providers can access the Drug Lookup feature by visiting the Alabama Medicaid website and clicking on the following link: http://medicaid.alabama.gov/content/4.0_Programs/4.3_Pharmacy-DME.aspx

Please note that the information found on the drug look up website applies to pharmacy claims only (i.e: pricing, PA requirements, and maximum quantity limits).

Any questions should be directed to the Provider Assistance Center at 1-800-688-7989.

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Multiple NDCs for a Single HCPCS Drug Code

At times it may be necessary for providers to report multiple NDCs for a single procedure code. If two or more NDCs are to be submitted for a procedure code, the procedure code must be repeated on separate lines for each unique NDC. On the first line, the procedure code, NDC and procedure quantity are reported with a **KP modifier** (first drug of a multi drug). On the second line, the procedure code, NDC and procedure quantity are reported with a **KQ modifier** (second/subsequent drug of a multi drug). When reporting more than two NDCs per procedure code, the KQ modifier is also used on the subsequent lines.

Unclassified Drugs

A provider who administers a physician drug not listed should use the following J codes:

- J3490 - Unclassified Drugs
- J3590- Unclassified Biologics
- J9999 - Not otherwise classified, antineoplastic drugs.

The claim must be sent on paper with a description of the drug attached. Providers should submit a red drop-out claim with the complete name of the drug, total dosage that was administered and a National Drug Code (NDC) number. Please be sure to search the Physician Drug List to see if the drug is possibly under a generic name. The claims containing the unclassified procedure code must be sent to: Gainwell, Attn: Medical Policy, PO Box 244032, Montgomery, AL 36124-4032. Gainwell will determine the price of the drug.

The Alabama Medicaid Agency supports the avoidance of wasted (discarded) medicine whenever possible. Medicaid accepts the use of modifier JW on a second line item to indicate the wasted (discarded) amount of medication.

Breathing/Inhalation Treatment: J2545 Pentamidine Isethionate (Nebupent)

Current coverage policy for breathing or inhalation treatments utilizing drugs such as Albuterol does not allow for the drug to be billed for separately as it is considered a component of the treatment charge. The exception to this policy is the administration of Pentamidine Isethionate.

Pentamidine isethionate (J2545), given by inhalation, is an anti-microbial agent specifically indicated for the prevention of Pneumocystis carinii pneumonia (PCP) in high-risk HIV infected patients. Administration of Pentamidine is done via the Respirgard II nebulizer which utilizes a series of one-way valves and a filter to minimize the release of aerosol droplets into the air. CPT code 94642 (aerosol inhalation of Pentamidine for pneumocystis carinii pneumonia treatment or prophylaxis) is the appropriate code to bill for administration of the drug. This therapy is generally given on a monthly basis and given in the hospital or clinic/office by a health care professional. The administration code does not include the cost of the drug. The inhalation drug code and the administration of the drug should both be reported on the same claim, same date of service.

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340B Drug Pricing

The Veterans Health Care Act of 1992 enacted section 340 B of the Public Health Services Act, "Limitation on Prices of Drugs Purchased by Covered Entities". This Section provides that a manufacturer who sells covered outpatient drugs to eligible 340B entities must sign a pharmaceutical pricing agreement with the Secretary of Health and Human Services in which the manufacturer agrees to charge to Medicaid a price for covered outpatient drugs that will not exceed the average manufacturer price decreased by a rebate percentage.

Eligible 340B entities are defined in 42 U.S.C. are defined in 42 U.S.C. § 256b(a)(4).

When an eligible 340B entity, other than a disproportionate share hospital, a children's hospital excluded from the Medicare prospective payment system, a free-standing cancer hospital exempt from the Medicare prospective payment system, sole community hospital, rural referral center, or critical access hospital, submits a bill to the Medicaid Agency for a drug purchased by or on behalf of a Medicaid recipient, the amount billed shall not exceed the entity's actual acquisition cost for the drug, as charged by the manufacturer at a price consistent with the Veterans Health Care Act of 1992, plus the dispensing fee established by the Medicaid Agency.

A disproportionate share hospital, children's hospital excluded from the Medicare prospective payment system, free-standing cancer hospital exempt from the Medicare prospective payment system, sole community hospital, rural referral center, or critical access hospital may bill Medicaid the total charges for the drug. As manufacturer price changes occur, the entities must ensure that their billings are updated accordingly.

Eligible 340B entities are identified on the Department of Health and Human Service's website. These entities shall notify Medicaid of their designation as a 340B provider.

Audits of the eligible 340B entities' (claims submissions and invoices) will be conducted by the Medicaid Agency. Eligible 340B entities, other than the providers listed above, must be able to verify acquisition costs through review of actual invoices for the time frame specified. Charges to Medicaid in excess of the actual invoice costs will be subject to recoupment by the Medicaid Agency in accordance with Chapter 33 of the Administrative Code.

Medicare/Medicaid Drugs

Medicare Part B covers some drugs in a physician's office. If the recipient is dually eligible for Medicare and Medicaid, the drug code as required by Medicare should be billed first to Medicare. The claim should crossover to Medicaid for consideration of payment. If the claim does not crossover to Medicaid, providers will need to submit the appropriate HCPCS code to Medicaid on a Medical Medicaid/Medicare Related Claim (aka Crossover Form 340) with Medicare allowance/payment/coinsurance/ and deductible.

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Medicare Part D drugs are a pharmacy benefit and should not be billed to Medicaid by physicians or outpatient facilities. Part D drugs are billed to Medicare on a pharmacy claim with the NDC number.

Not all drugs listed on the Physician Drug Fee Schedule are considered Part B drugs. Self Administered drugs are generally considered non-covered for Part B benefits. Coverage of Physician Drugs may be found on Medicaid's website at www.medicaid.alabama.gov or by AVRS or Provider Assistance Center at 1-800-688-7989.

Site-Specific Injections

Both the relevant CPT and J codes are billed. For example, a subconjunctival injection to the eye would be billed as 68200 (CPT) with a separate J code for the drug; thus, site specific injections are submitted as two lines.

EVALUATION AND MANAGEMENT CODES BILLED IN CONJUNCTION WITH DRUG ADMINISTRATION CODES

Effective for Dates of Service 01/01/2006 and Thereafter

When an Evaluation and Management service is provided *and* a Drug Administration code (96372, 96373, 96374, 96375 and 96376) is provided at the same time, the E & M code, Drug Administration Code, and the HCPCs Code for the drug may be billed. A **Significant Separately Identifiable Service** must be performed in conjunction with the Drug Administration code for consideration of payment for the Evaluation and Management Code. A **Modifier 25** must be appended to the E&M service for recognition as a "**Significant Separately Identifiable Service".** Medical Record documentation must support the medical necessity of the visit as well as the level of care provided.

However, when no **Significant Separately Identifiable** E & M service is actually provided at the time of a Drug Administration, an E & M code should not be billed. In this instance, the Drug Administration Code and the HCPCs Code for the drug may be billed. An example of this is routine monthly injections like B-12, iron, or Depo-Provera given on a regular basis without a **Significant Separately Identifiable** E & M service being provided.

When an Evaluation and Management service is provided and an Administration Code for Hydration (96360, 96361), Therapeutic, Prophylactic, and Diagnostic Infusion (96365, 96366, 96367 and 96368) and Chemotherapy Administration Code (96401-96542) is provided at the same time/encounter, the E&M code and Administration code may be billed. A **Significant Separately Identifiable Service** must be performed in conjunction with these administration codes for consideration of payment for the Evaluation and Management Code. A **Modifier 25** must be appended to the E & M service for recognition as a **"Significant Separately Identifiable Service".** Procedure Codes 99211 will not be allowed with Modifier 25 or in conjunction with the administration codes for the same date of service. Medical record documentation must support the

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medical necessity and level of care of the visit. These services are subject to post payment review.

NOTE:
In accordance with Section 5042 of the SUPPORT Act, effective October 1, 2021, prescibers of Medicaid eligible recipients are required tocheck the Alabama PDMP (Prescription Drug Monitoring Program) prior to prescribing a Schedule II controlled substance. If the presciber does not check the PDMP, the prescriber is required to document the reason in the medical record. Exclusions to this requirement include prescriptions written for hospice patients, patients with an active cancer diagnosis, residents of a long-term care nursing facility, and children under the age of 18 (Schedule II prescription for ADHD only).

Chemotherapy Injections

Alabama Medicaid has established the following new guidelines that should be utilized by physicians when billing for administration codes.

- For non-chemotherapy injections, services described by CPT codes 96372, 96374, and 96375 may be billed in addition to other physician fee schedule services billed by the same provider on the same day of service.

- For IV infusions and chemotherapy infusions, if a significant separately identifiable E & M service is performed, the appropriate E & M CPT code should be reported utilizing modifier 25.

- When administering multiple infusions, injections, or combinations, only one “initial” drug administration service code should be reported per patient per day, unless protocol requires that two separate IV sites must be utilized. The initial code is the code that best describes the service the patient is receiving and the additional codes are secondary to the initial code.

- “Subsequent” drug administration codes, or codes that state the code is listed separately in addition to the code for the primary procedure, should be used to report these secondary codes. If an injection or infusion is of a subsequent or concurrent nature, even if it is the first such service within that group of services, then a subsequent or concurrent code from the appropriate section should be reported.

- If the patient has to come back for a separately identifiable service on the same day, or has 2 IV lines per protocol, these services are considered separately billable with a modifier 76.
- Medicaid will not pay for chemotherapy administration in a hospital setting, and claims for these codes with modifier 26 will not be recognized.

Please refer to Chapter 19 (Hospitals) for details on chemotherapy administration and infusion therapy.

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Drugs Requiring Prior Authorization

EXAMPLE:

Effective September 1, 2006, injectable drug Orencia (New Code in 2007 - J0129) will require prior authorization as a biological through Health Information Designs (HID) prior to treatment. After receiving authorization from HID, a CMS-1500 paper claim must be submitted to Gainwell including the dosage and NDC number. The letter of approval from HID must be attached to the claim, and "attachment" in block 19. These drugs must be approved through HID prior to administering and billing. HID may be contacted at 1-800-748-0130. The Prior Authorization forms are located on our website at www.medicaid.alabama.gov.

Allergy Treatments

Physicians may bill for antigen services using only the component codes (i.e., the injection only codes 95115 or 95117) and/or the codes representing antigens and their preparation (i.e., codes 95144 through 95170). Physicians providing only an injection service must bill for only code 95115 or code 95117. Professional services for allergen immunotherapy multiple injections (procedure codes 95117 and 95125) should be billed using only one unit. Effective April 1, 2003, the Agency will deny claims for these procedure codes when more than one unit is billed.

Physicians providing only the antigen/antigen preparation service would bill the appropriate code in the range of 95144 through 95170. Physicians providing both services would bill for both services. This includes allergists who provide both services through the use of treatment boards.

Physicians will no longer use the "complete" service codes, and instead must bill for both the injection and the antigen services separately, even though the current CPT definitions of the antigen codes refer to vials and the physicians using treatment boards do not create vials.

Procedure codes 95144 - 95170 are used for the provision of single or multi-dose vials of allergenic extract for single patient use only. These procedures should only be billed at the time that these vials are supplied to the patient.

In the November 2006 Insider, an article was published to announce a change in the maximum number of allowed units for allergen immunotherapy. Medicaid is providing clarification to guide physicians who bill for the provision of allergen immunotherapy. Medicaid allows billing for the allergen at the time an individual vial is first used for a patient, but not for the entire amount of allergen/dilution prepared for the patient at once as this would likely exceed the maximum number of allowed units.

Procedure Code 95165 represents the preparation of vials of non-venom antigens. The reimbursement for procedure code 95165 is based on preparing a vial containing a mixture of all the appropriate antigens plus diluents and calculating the billing units in the vial.

Therefore, one (1) cc equals one (1) billing unit. The actual number of doses received by a patient may differ significantly from the number of billing units.

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When a multidose vial contains less than 10cc, physicians should bill Medicaid for the number of 1cc billing units that may be removed from the vial. If a physician prepares two 10cc vials containing **different allergens**, he/she may bill Medicaid for a total of 20 billing units (10 billing units per vial).

The maximum number of billable units (two-10cc vials) for procedure code 95165 was set as "20" effective November 1, 2006. If multiple vials are prepared at one time, each vial should be billed when that vial is opened for use for the patient. Administration of vaccine may continue to be billed as each dose is given in the physician's office. Medical record documentation must clearly support the treatment plan, each vial used, antigens, dosage, and changes in the treatment regime.

Claims exceeding 20 billing units (such as two 10cc vials containing different allergens) will require manual processing by sending a clean claim with medical justification, medical records, and supporting fact based documentation to:

Alabama Medicaid Agency
P.O. Box 5624
Montgomery, Alabama, 36104
Attention: Medical Support Programs

Calculation of Billing Units and Wastage

HCPCS code for J0587 reads "per 100 units". Therefore, 100 units of J0587 will equal one billing unit. However, because of the expense of the drug, physicians are encouraged to schedule patients in a manner that they can use botulinum toxin most efficiently. For example, a physician schedules three patients requiring botulinum toxin type A on the same day within the designated shelf life of the drug (shelf life is four hours). The physician administers 30 units to all three patients and bills 30 units for the first two patients and 40 units for the last patient. The physician would bill 40 units for the last patient because the patient received 30 units but the physician had to discard 10 units.

HCPCS code for J0585 reads "per unit". Therefore this code requires the units of service on the claim to reflect the number of units used. However, if a physician must discard the remainder of a single does vial (sdv) after administering it to a patient, the Agency will cover the amount of the drug discarded along with the amount administered. For example, a physician administers 15 units of botulinum toxin type A and it is not practical to schedule another patient who requires botulinum toxin. Situations that are impractical to schedule another patient include (a) it is the first time the physician has seen the patient and did not know the patient's condition or (b) the physician has no other patients who require botulinum toxin injections.

Documentation requirements must include the exact dosage of the drug given and the exact amount of the discarded portion in the patient's medical record as well as the corresponding diagnosis. However, if no benefit is demonstrable by two sets of injections, further injections will not be considered medically necessary.

Modifier JW

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The Agency supports the avoidance of wasted (discarded) medicine whenever possible. Medicare requests the use of modifier JW on a second line item to indicate the wasted (discarded) amount of medication. Medicaid accepts the use of modifier JW, but total units must not exceed maximum number of allowed units.

Units of Service

Physician drug maximum number of units allowed are calculated based on a "per dose" basis, and by the narrative description of the HCPCS code. Some dosages are inherent in the narrative description of the codes and will assist in determining the number of units to file. When administering a lesser or greater dosage than the narrative description providers should round the billing unit up to the closest amount charted. For example, J0290, Ampicillin, up to 500 mg:

If administering 1000mg, bill 2 units
750 mg, bill 2 units
500 mg, bill 1 unit
125 mg, bill 1 unit

Exception: Bicillin CR and Bicillin LA

Effective January 1, 2011, Bicillin CR and Bicillin LA will be priced on a 100,000 unit per ML basis. As well, the HCPCS codes have been condensed into two vs. six codes:

If administering Bicillin CR, bill J0558 (replaces J0530, J0540 and J0550)

If administering Bicillin LA, bill J0561 (replaces J0560, 05670 and J0580)

One of the two HCPCS codes should be chosen based on the drug description. The number of billing units would then be derived by dividing the dosage by 100,000 units. Fractions of billing units are rounded up to the next whole unit.

Example: If the dosage of Bicillin LA is 1,800,000 units, choose the appropriate procedure code. In this case procedure code J0561 is the appropriate code to be used. Next, take the dosage given (1,800,000 units) and divide by 100,000 units to obtain the billing units. This dosage would yield 18 billing units (1,800,000 /100,000 = 18 units) for code J0561.

Flu Vaccination

For influenza vaccine procedure codes covered under the Vaccines for Children (VFC) Program to eligible children less than nineteen years of age, refer to Appendix A, Well Child Check-Up (EPSDT).

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Influenza vaccines are covered fee-for-service (vaccine medication) for ages nineteen and above. For more specific information on coverage, you may call the Provider Assistance Center at 1 (800) 688-7989.

Vaccines for Children (VFC)

The Vaccines for Children (VFC) Program offers free vaccines to qualified health care providers for children who are 18 years of age and under who are Medicaid eligible, uninsured, American Indian or Alaskan Native, or the under insured. Providers must be enrolled in the VFC Program to receive any reimbursement for the administration of immunizations provided to recipients 0-18 years of age. The Alabama Department of Public Health administers this program.

Medicaid tracks usage of the vaccine through billing of the administration fee using CPT codes. Refer to Appendix A, Well Child Check-Up (EPSDT), for covered CPT codes.

ImmPRINT Immunization Provider Registry

The Alabama Department of Public Health has established a statewide immunization registry. Please visit their website at https://siis.state.al.us for more information.

Stand-alone Vaccine Counseling Codes

The following procedure codes may be used for stand-alone vaccine counseling for recipients under 21 years of age.

Procedure Code	Procedure Code Description
G0312	Immunization counseling by a physician or other qualified health care professional when the vaccine(s) is not administered on the same date of service for ages under 21, 5 to 15 mins time.
G0313	Immunization counseling by a physician or other qualified health care professional when the vaccine(s) is not administered on the same date of service for ages under 21, 16-30 mins time.
G0314	Immunization counseling by a physician or other qualified health care professional for COVID-19, ages under 21, **16-30** mins time.
G0315	Immunization counseling by a physician or other qualified health care professional for COVID-19, ages under 21, **5-15** mins time.

Added: Stand-alone Vaccine…minutes of time

- These procedure codes are to be used when ONLY providing vaccine counseling to a recipient under age 21, and the recipient does NOT receive a vaccine on the day of service.

NOTE:
G0315 is for 5-15 minutes of time; whereas, G0314 is for 16-30 minutes of time.

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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 using the appropriate CPT code. The administration fee is included in the price of the vaccine. The administration fee may be billed separately if an office visit is not billed.

Provider should bill only the vaccine administration fee if the vaccine is provided at no cost to the provider from federal resources.

If a 90000s CPT vaccine code does not have a rate, a manual review will need to be submitted. A paper claim should include the following:

- Form 402
- A clean red drop-out ink CMS Form 1500 containing the vaccine procedure code
- Documentation of the total dosage that was administered
- Invoice with the complete name of the drug and a National Drug Code (NDC) number.

Added: If a 90000s…Montgomery, AL 36103-5624

Claims may be submitted to:

Alabama Medicaid Agency
Attn: Dental / EPSDT / Physician Division
501 Dexter Avenue
P.O. Box 5624
Montgomery, AL 36103-5624

Radiopharmaceutical Drugs (Invoice Priced)

A provider who administers a Radiopharmaceutical drug not priced on the www.palmettogba.com website should use the following criteria:

- The claim must be sent on paper with a description of the drug attached.
- Providers should submit a red drop-out ink claim with the complete name of the drug, total dosage that was administered and a National Drug Code (NDC) number.
- The claims containing the radiopharmaceutical procedure code must be sent to:

  Gainwell, Attn: Medical Policy
  PO Box 244032
  Montgomery, AL 36124-4032

Gainwell will determine the price of the drug.

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H.2 Physician Drug Fee Schedule

Physician Adminstered Drugs are those that are administered in the Physician's office or outpatient facility. A covered outpatient drug is broadly defined as a drug that may be dispensed only upon prescription and is approved for safety and effectiveness by the FDA. Physician administered drugs are not restricted to injectable drugs only but include any drug regardless of the method of administration.

The inclusion or exclusion of a procedure code does not imply Medicaid coverage, reimbursement, or lack thereof. To inquire regarding any restrictions/limits on these procedure codes, please consult the Provider Assistance Center at 1-800-688-7989 or AVRS at 1-800-727-7848. The pricing file must be verified to determine coverage and reimbursement amounts.

The Physician Drug Fee Schedule is located on the Alabama Medicaid website and can be accessed by clicking the following link: http://medicaid.alabama.gov/content/Gated/7.3G_Fee_Schedules.aspx

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I ASC Procedures List

CPT codes on the ASC fee schedule are currently covered for ambulatory surgical centers billing.

NOTE:

The ASC fee schedule is used for scheduling Medicaid recipients for outpatient surgeries. Occasionally Medicaid recipients question what procedures Medicaid covers.

Before performing any procedure, providers need to inform the recipient that the recipient is responsible for payment of services that Medicaid does not cover.

Use the AVRS line at Gainwell (1(800) 727-7848) to verify if it is a covered procedure code. Submit requests to add procedure codes to this list in writing to the Alabama Medicaid Agency, 501 Dexter Avenue, P. O. Box 5624, Montgomery, AL 36103-5624, Attention: Medical Services Division.

An" X" in the PA column indicates that the procedure requires prior authorization. Mail your written request for prior authorization and supporting documentation of extenuating circumstances and the procedure code to Gainwell, Attn: Prior Authorization. P. O. Box 244032, Montgomery, AL 36124-4032.

An "X" in the Under 21 column indicates that the procedure requires an EPSDT referral or is for QMB recipients only.

NOTE:

Benefit limits may also apply in addition to the hard-coded maximum units.

The inclusion or exclusion of a procedure code on the ASC fee schedule does not imply Medicaid coverage or reimbursement. The pricing file must be verified to determine coverage and reimbursement amounts for the specific date of service. ASCs may bill surgical procedures within the range of 10000 - 69XXX as well as the dental code D9420.

The fee schedule for Appendix I is located on the Medicaid's website at www.medicaid.alabama.gov under: Providers>Fee Schedules>Ambulatory Surgical Center Fee Schedule (Excel Version).

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J

J. Provider Remittance Advice (RA) Codes

NOTE:

Effective January 1, 2015, Appendix J: Provider Remittance (RA) Codes will be replaced with a dedicated link on the Alabama Medicaid Agency website at

http://medicaid.alabama.gov/content/7.0_Providers/7.6_Manuals.aspx

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K Top 200 Third Party Carrier Codes

This appendix lists the top 200 insurance companies that may be a third-party resource for payment of claims. The company name and carrier codes are listed numerically in Section K.1, Numerical Listing by Company Code, and alphabetically in Section K.2, Alphabetical Listing by Company Name.

Because federal Medicaid regulations require that any resources currently available to a recipient, be considered in determining liability for payments of medical services, providers have an obligation to investigate and report the existence of other insurance or liability to Medicaid. When you identify a third party resource, you should submit the claim to that resource.

Refer to Section 3.3.6, Third Party Liability, for more information about how to file a claim when another insurance company may be responsible for all or part of the cost of the medical care.

K.1 Numerical Listing by Company Code

Company Code	*Company Name*	*City, State*
00002	AARP Insurance Plan	Philadelphia, PA
00007	Aetna Life and Casualty Company	Tampa, FL
00020	Amalgamated Life Insurance Company	New York, NY
00031	American Family Life Insurance	Columbus, GA
00039	American Heritage Life	Jacksonville, FL
00067	Assoc Doctors Health and Life	Longhorne, PA
00073	Atlantic American Life	Atlanta, GA
00081	Bankers Life and Casualty Company	Chicago, IL
00128	Colonial Life and Accident	Columbia, SC
00143	Connecticut General Life Insurance Company	Atlanta, GA
00231	Globe Life and Accident	Oklahoma City, OK
00253	American General Gulf Life	Mobile, AL
00272	Independent Life and Accident	Nashville, TN
00291	John Hancock Mutual Life	Greensboro, NC
00306	Liberty National	Birmingham, AL
00310	Life Insurance Company of Alabama	Gadsden, AL
00314	Life Insurance Company of Georgia	Atlanta, GA
00337	Unicare	Springfield, MA
00341	Metropolitan Life	Tampa, FL
00358	Mutual of Omaha Insurance	Omaha, NE
00360	Mutual Savings Life	Decatur, AL
00366	National Home Life Assurance	Valley Forge, PA
00370	American General Life	Nashville, TN
00376	National Security	Elba, AL
00388	New Southland National	Tuscaloosa, AL
00439	Physicians Mutual	Omaha, NE
00445	Pioneer Life Insurance Company	Rockford, IL
00453	Professional Insurance Corporation	Raleigh, NC

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Company Code	*Company Name*	*City, State*
00454	Protective Industrial	Birmingham, AL
00455	Protective Life Insurance Company	Birmingham, AL
00461	Prudential Insurance Company	Jacksonville, FL
00474	Ret/Wholesale O Store International	Birmingham, AL
00514	State Farm Insurance Company	Birmingham, AL
00531	Time Insurance Company	Milwaukee, WI
00544	Union Bakers Insurance Company	Dallas, TX
00546	Union Fidelity Life Insurance	Trevose, PA
00550	Union National Life Insurance Company	Baton Rouge, LA
00553	United American Insurance Company	McKinney, TX
00606	New York Life Insurance Company	Atlanta, GA
00614	Boilermakers National	Kansas City, KS
00624	Goodyear	Gadsden, AL
00626	Great West Life Assurance	Atlanta, GA
00633	Life Investors Insurance Company	Cedar Rapids, IA
00640	National Association of Letter Carriers	Ashburn, VA
00706	Provident Life and Accident	Chattanooga, TN
00779	Unicare	Fort Scott, KS
00881	Provident Life Insurance	Greenville, SC
00906	AETNA Life and Casualty	Arlington, TX
00929	Prudential Ins Co.	Jacksonville, FL
01002	United of Omaha	Omaha, NE
01045	KANWHA Ins Co.	Lancaster, SC
01046	Wausau Ins. Co.	Wausau, WI
01085	Provident Life & ACC	Bristol, TN
01110	Combined Ins. Co. of America	Chicago, IL
01114	Mail Handlers Benefit Plan	Rockville, MD
01119	Aetna Life & Casualty	Minneapolis, MN
01158	Aetna Life & Casualty	Memphis, TN
01165	Aetna Life & Casualty	Greensboro, SC
01174	John Alden Life Ins. Co.	Miami, FL
01200	Golden Rule Ins. Co.	Indianapolis, IN
01234	Aetna Insurance Co.	Peoria, IL
01248	Aetna Life & Casualty	Allentown, PA
01264	United Ins. Of America	Baton Rouge, LA
01303	Metropolitan	Utica, NY
01395	Aetna Insurance Co.	Tyler, TX
01427	Metrahealth Travellers	Salt Lake City, UT
01460	Grp Resource Inc.	Duluth, GA
01476	Prime Health	Mobile, AL
01523	Southeast Health Plan Ins.	Birmingham, AL
01582	United Health Care	Birmingham, AL
01613	Prime Health ADM	Mobile, AL
01626	Hilb, Rogal, & Hamilton	Birmingham, AL
01650	Metropolitan Life Insurance	Pittsburgh, PA
01676	National Foundation Life	Ft. Worth, TX
01718	Principal Financial Group	Springfield, MO
01723	Metropolitan Life	Greenville, SC
01740	United Food and Com Workers	Atlanta, GA
01828	Capitol American Life	Cleveland, OH
01894	Delta Dental Plan of Ohio	Columbus, OH

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Company Code	*Company Name*	*City, State*
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
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

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Company Code	*Company Name*	*City, State*
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
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

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Company Code	*Company Name*	*City, State*
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
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

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Company Code	*Company Name*	*City, State*
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
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

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Company Code	*Company Name*	*City, State*
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
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

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Company Code	*Company Name*	*City, State*
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
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

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Company Code	*Company Name*	*City, State*
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

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L AVRS Quick Reference Guide

The Alabama Medicaid Automated Voice Response System (AVRS) enables providers to access information regarding check amount, claim status, recipient eligibility and third party resources, drug and procedure code pricing, prior authorization requirements, and recipient household information. When you dial 1 (800) 727-7848, you can access this information 18-20 hours per day, seven days a week. This guide is intended to help you use AVRS quickly, accurately, and efficiently.

This quick reference guide consists of the following sections:

In This Section	***You Can Find Out About***
AVRS Basics	General information, such as hours of operations and the type of information available on AVRS; AVRS spoken requests and responses; function keys; and time-outs, invalid data, and errors. **Please note the alphabetic table in Section L.1.3, Special Function Keys, which provides a number combination for each letter of the alphabet. Providers who must enter alphabetic characters in AVRS should refer to this section for instructions.**
Accessing AVRS	Using the main menu and enter valid provider number. **You must enter a valid provider number to access any AVRS information. Option 0, the Provider Assistance Center, will be available during normal business hours 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 Fee-for-service Claims Status	Selecting the appropriate main menu option and entering valid data to verify claims status.
Verifying Recipient Eligibility	Selecting the appropriate main menu option and entering valid data to verify recipient eligibility. **Providers have the option of receiving the eligibility response via fax. The instructions are included in this section.**
Accessing Pricing Information	Selecting the appropriate menu options and entering valid data to access pricing information for NDCs or procedure codes.
Accessing Fee-for-service Prior Authorization Information	Selecting the appropriate menu option and entering valid data to access information about approved prior authorizations.
Accessing Household Information	Selecting the appropriate menu options and entering valid data to access information for recipient household members. **Providers have the option of receiving the household information response via fax. The instructions are included in this section.**

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NOTE:

All AVRS responses are based on the information entered by the caller. Data is provided for informational purposes and is current only as of the inquiry date. This information is not a guarantee of payment. Claims submitted for payment are subject to system audits (medical policy), edits, and applicable limitations.

L.1 AVRS Basics

This section provides general information about AVRS that will help you use AVRS more efficiently and effectively. It provides general information on how to access AVRS and what information is provided and describes AVRS spoken requests and responses, special function keys, and global messages. Of particular importance is the alphabetic table, described in Section L.1.3, Special Function Keys, providing number combinations corresponding to the letters of the alphabet. Providers who must enter data that contains both numbers and letters should read this section.

L.1.1 General Information

AVRS is available approximately 18-20 hours per day, 7 days per week. Scheduled down times usually occur during off-peak hours, such as late at night or very early in the morning.

To access AVRS, you must use a touch tone phone. Providers with rotary dial phones should contact the Gainwell Provider Assistance Center, from 8:00 a.m. until 5:00 p.m., Monday through Friday. For Pharmacy Providers only, the Pharmacy Help Desk is also available from 7:00 a.m. until 8:00 p.m. Monday through Friday, and on Saturdays from 9:00 a.m. to 5:00 p.m., and can be accessed by dialing 1 (800) 456-1242. Please refer to the Alabama Medicaid Provider Insider, a quarterly bulletin sent to Alabama Medicaid providers, for holiday schedules.

NOTE:

It is important to have all necessary information on hand prior to calling AVRS. AVRS is designed to give callers several chances to enter or correct data; however, the system will terminate the call if you fail to enter correct data within the allowed number of attempts, or if you cause the system to time-out. Please refer to Section L.1.4, Time-outs, Invalid Data, and Errors, for more information.

AVRS enables callers to access the following data:

Press Menu Option	*To Retrieve Information About*
1	Check amount for the current checkwrite.

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Press Menu Option	*To Retrieve Information About*
2	Claim status, including the following information for pharmacy, Medicare-related, and non-Medicare related claims: • Paid amount and checkwrite date for paid claims • Message that the claim is in process for suspended claims • EOB codes and RA date for claim denials • Procedure or revenue code that denied or partially paid (for non-Medicare related claims, as appropriate) • ICN for fully or partially refunded claims
3	**Recipient eligibility verification** (option 1 on the sub-menu), including the following eligibility information: • Check digit for recipient number entered • Recipient last and first names • Current recipient number and check digit • Issue number for recipient ID card • Recipient date of birth and sex • Eligibility start and stop dates corresponding to the month of eligibility entered • Screening information, if selected (Screening information includes both fee-for-service and encounter related if applicable) • City • State • ZIP code • County code • Maternity waiver information, if applicable • Recipient aid category • Lock-in, lock-out, Long Term Care, and waiver information • Medicare HMO information and HIC number • Attributed PCP Provider information, if applicable • Managed care information, including plan, PMP name, phone number, and 24-hour phone number • ACHN enrollment, if applicable • Recipient Application Status, if applicable 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) (Benefit limits are fee-for-service only), including inpatient, outpatient, and physician counts; eyeglass limitation counts; dental limits; and other counts • **Other insurance** (option 3 on the sub-menu), including the following third party policy information (for up to three policies): – Policy number – Company code and group number – Subscriber name and SSN – Coverage dates – Policy coverage information – Coverage limitation – Health Insurance Premium (HIP) information
4	Drug pricing information for the dispensed date entered, including prior authorization requirements
5	Procedure code pricing information, including prior authorization requirements and procedure coverage information, if applicable
6	Prior authorization verification for procedure code or NDC, including prior authorization number, status, start date, stop date, units or dollars authorized, and units or dollars used

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Press Menu Option	*To Retrieve Information About*
7	Recipient household members. Allows the user to find a recipient Medicaid number for a member of the recipient's household. Information returned includes the following: - member number - name - date of birth - race - sex - certifying program

L.1.2 AVRS Spoken Requests and Responses

AVRS provides a spoken response to queries entered using a touch tone phone. Based on the information you enter, or the menu options you select, AVRS will provide a custom response. AVRS does this by translating responses to the data you enter into speech patterns.

Messages are spoken as recorded, because these do not change. However, other words, such as names, are spelled out. For instance, AVRS translates the last name "Doe" as D-O-E.

Likewise, AVRS speaks number values one number at a time. For example, the number '155' is spoken as 'one-five-five', rather than 'one hundred fifty-five'.

If the response represents a dollar amount, AVRS provides the response in a monetary format. For example, the dollar value '128432' is represented as 'one thousand, two hundred eighty-four dollars and thirty-two cents'.

AVRS translates date responses in a Gregorian format (the manner in which most of us express dates). For instance, the date '05/14/1999' is spoken as 'May fourteenth, nineteen ninety-nine'.

L.1.3 Special Function Keys

You will receive better, faster results using AVRS if you understand how to use the following special function keys.

End of Data

Because the length of data you enter may vary (for instance, while most Alabama Medicaid provider numbers have nine-digit numbers, some have eight-digit numbers, and all National Provider Identifier (NPI) numbers have ten digits), you must signal AVRS when you have finished entering data. The pound sign (#) is the symbol you use to do this. You should always enter the pound sign key to mark the end of the data you have just entered. The following examples illustrate how to use the pound sign (#) to mark the end of data:

To enter provider number 123456789	Press 123456789#
To enter procedure code 11111	Press 11111#

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Repeat Response or Prompt

AVRS is designed to provide you the information you need by using a series of prompts and responses. The system 'speaks' requests to you, such as available menu options, or a request to enter data. If you want AVRS to repeat the message, press the asterisk (*) key on your touch tone phone.

Alphabetic Data

AVRS uses information keyed on a touch tone phone, which does not provide a key for each letter of the alphabet. Sometimes, you will have to enter data that contains letters as well as numbers (for instance, some Alabama Medicaid provider numbers contain letters and numbers). To do this, you must use a combination of the asterisk (*) key and **two** numbers to represent a particular letter.

The table below describes the number combinations that represent the letters of the alphabet:

A - *21	G - *41	M - *61	S - *73	Y - *93
B - *22	H - *42	N - *62	T - *81	Z - *12
C - *23	I - *43	O - *63	U - *82	
D - *31	J - *51	P - *71	V- *83	
E - *32	K - *52	Q - *11	W - *91	
F - *33	L - *53	R - *72	X - *92	

Using this table as a guide, enter data with a combination of letters and number in the following way:

Actual Provider Number	ABC0099D
Enter the following in AVRS	*21 *22 *23 0099 *31
AVRS reads back this number	ABC0099D

L.1.4 Time-outs, Invalid Data, and Errors

AVRS can respond only to what is entered by you, the caller. To receive information from AVRS, you must enter valid data in the correct format. When you make an error or fail to enter information when prompted, AVRS gives you another chance to correct the mistake. If you do not correct the error or respond in a timely fashion, AVRS will end the call.

Maximum Errors Exceeded

You have three chances to enter correct data when prompted. If you exceed the limit, AVRS plays the following message:

> *We're sorry – the data you entered is invalid. If you would like assistance from the Provider Assistance Center, press 0.*

If you press 0, AVRS transfers you to the Provider Assistance Center, which will assist you during normal business hours. If you do not press 0 within 10 seconds, AVRS ends the call.

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Maximum Time-outs Exceeded

You have ten seconds to enter requested data. The first time you exceed this limit, AVRS prompts you to enter the data. If you exceed the limit a second time, AVRS plays the following message:

> *You have not responded with the requested information. If you would like assistance from the Provider Assistance Center, press 0.*

If you press 0, AVRS transfers you to the Provider Assistance Center, which will assist you during normal business hours. If you do not press 0 within 10 seconds, AVRS ends the call.

Invalid Data

If you enter a value that is not described as a menu option (for instance, if you press '9' after listening to the main menu, when '9' is not a valid option), AVRS plays the following:

> *Invalid option. Please re-enter.*

AVRS then replays the menu options.

Maximum Transactions Exceeded

To ensure AVRS is available to all providers, you are limited to ten (10) transactions per phone call. For each main menu item, AVRS counts **one** transaction using the following criteria:

- For 'Check Amount,' (Option 1), each time you enter a different provider number
- For 'Claims Status' (Option 2), each time you check another claim for the same recipient, or each time you check a claim for a different recipient
- For 'Recipient Eligibility Verification' (Option 3), each time you verify eligibility for a recipient
- For 'Drug Pricing Information' (Option 4), each time you enter an NDC
- For 'Procedure Code Pricing Information' (Option 5), each time you enter a procedure code
- For 'Prior Authorization Verification' (Option 6), each time you enter a procedure code or NDC
- For 'Household Inquiry' (Option 7), each time you request an inquiry for recipient household information

When you exceed the ten transaction limit, AVRS ends the call after playing the following message:

> *In order to serve as many callers as possible, we must limit the number of inquiries per call. Please call again for any additional inquiries you may have.*

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L.2 Accessing the AVRS Main Menu

When you dial 1 (800) 727-7848 to access AVRS, the system supplies the following greeting:

> *Good morning (good afternoon, or good evening). Welcome to the Alabama Medicaid Voice Response Inquiry System.*

If the system is unavailable, the following message plays:

> *The Alabama Medicaid Voice Response Inquiry System is currently unavailable. Please call back later or call the Provider Assistance Center at 1 (800) 392-5741 between the hours of 8:00 a.m. and 5:00 p.m., Monday through Friday.*

If you wish to have confirmation after entering required information, press 1 when prompted. For the remainder of the call data entered will be repeated back to you and then ask you to confirm before continuing. Press 2 if you do not wish to have confirmation.

You must enter a valid NPI or Alabama Medicaid provider number to access any AVRS information. If your NPI is shared by multiple provider location ZIP codes and / or taxonomy numbers, you may be prompted to enter your nine-digit ZIP+4 code and, if necessary, your ten-digit taxonomy number.

If AVRS is available, the system provides the Main Menu. Callers may choose from the following menu options:

- Check amount (press 1)
- Claims status (press 2)
- Recipient eligibility verification (press 3)
- Drug pricing information (press 4)
- Procedure code pricing information (press 5)
- Prior authorization verification (press 6)
- Recipient household information (press 7)
- Provider Assistance Center (press 0)

Providers calling from a rotary phone are instructed to hold for the provider unit during normal business hours, or to call back during normal business hours to speak with a representative of the Provider Assistance Center.

L.3 Verifying a Check Amount

To verify a check amount, press 1 (the number one) from the Main Menu. AVRS prompts you to enter your National Provider Identifier (NPI) or Alabama Medicaid provider number. After AVRS verifies your NPI, the system returns the following information:

- Check amount for the current checkwrite

Once you have listened to the response, you may choose from the following options, as prompted by AVRS:

- Press 1 to repeat the checkwrite response
- Press 2 to check another claim on the same recipient
- Press 3 to check a claim on another recipient

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- Press 4 to obtain checkwrite information for another provider number
- Press 9 to return to the Main Menu
- Press 0 to speak with a Provider Assistance Center representative (please note that the Provider Assistance Center is available during normal business hours only)
- Hang up to end the call

NOTE:

AVRS returns check amount information based on the payee, or billing provider number. You must have a valid payee provider number in order to complete a successful query. For group practices where several providers receive a single check, the check amount given will be for the entire group.

L.4 Accessing Claims Status

To access claims status, press 2 (the number two) from the Main Menu. AVRS prompts you for your NPI or billing provider number and the Alabama Medicaid recipient ID number entered on the claim form. Once you have entered this data, you may choose from the following options, as prompted by AVRS:

- Press 1 for pharmacy claims
- Press 2 for non-Medicare related claims
- Press 3 for Medicare related claims
- Press 9 to return to the Main Menu
- Press 0 to speak with a Provider Assistance Center representative (please note that the Provider Assistance Center is available during normal business hours only)

L.4.1 Pharmacy Claim Status

To access claims status for pharmacy claims, you must enter the following data:

- Eleven-digit NDC, followed by the pound sign
- Dispensed date in MMDDCCYY format, followed by the pound sign
- Billed amount, including dollars and cents, followed by the pound sign. **Do not include a decimal point. You may enter a maximum of nine digits.**

AVRS has now collected the required input data, and can perform a query to retrieve the requested information. If AVRS cannot find a match for the provider or recipient, the system prompts you to re-enter the data. If the provider and recipient data are valid, AVRS returns one of the following responses:

- System could not find a claim that matches the search criteria
- Paid amount, checkwrite date, and ICN for paid claims
- Message that the claim is in process for suspended claims

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- EOB codes and RA date for claim denials

The system also returns similar messages if more than one claim matches the search criteria. Once you have listened to the response, you may choose from the following options, as prompted by AVRS:

- Press 1 to repeat the claim status response
- Press 2 to check another claim for the same recipient
- Press 3 to check a claim for another recipient
- Press 4 to enter another provider number
- Press 9 to return to the Main Menu
- Press 0 to speak with a Provider Assistance Center representative (please note that the Provider Assistance Center is available during normal business hours only)
- Hang up to end the call

L.4.2 Non-Medicare Claim Status

To access claims status for non-Medicare claims, you must enter the following data:

- From date of service in MMDDCCYY format, followed by the pound sign
- Through date of service in MMDDCCYY format, followed by the pound sign
- Billed amount, including dollars and cents, followed by the pound sign. **Do not include a decimal point. You may enter a maximum of nine digits.**

AVRS has now collected the required input data, and can perform a query to retrieve the requested information. If AVRS cannot find a match for the provider or recipient, the system prompts you to re-enter the data. If the provider and recipient data are valid, AVRS returns one or more of the following responses:

- System could not find a claim that matches the search criteria
- Paid amount, checkwrite date, and ICN for paid claims
- Message that the claim is in process for suspended claims
- EOB codes and RA date for claim denials
- Line item number, procedure or revenue code, and EOB code for each denied line item
- Paid amount, checkwrite date, and ICN for partially paid claims
- Line item, procedure or revenue code, and paid amount for each paid detail on a partially paid claim
- Line item, procedure or revenue code, and EOB code for each denied detail on a partially paid claim

The system also returns similar messages if more than one claim matches the search criteria. Once you have listened to the response, you may choose from the following options, as prompted by AVRS:

- Press 1 to repeat the claim status response
- Press 2 to check another claim for the same recipient

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- Press 3 to check a claim for another recipient
- Press 4 to enter another provider number
- Press 9 to return to the Main Menu
- Press 0 to speak with a Provider Assistance representative (please note that the Provider Assistance Center is available during normal business hours only)
- Hang up to end the call

L.4.3 Medicare Claim Status

To access claims status for Medicare claims, you must enter the following data:

- From date of service in MMDDCCYY format, followed by the pound sign
- Through date of service in MMDDCCYY format, followed by the pound sign
- Billed amount, including dollars and cents, followed by the pound sign. **Do not include a decimal point. You may enter a maximum of nine digits.**

AVRS has now collected the required input data, and can perform a query to retrieve the requested information. If AVRS cannot find a match for the provider or recipient, the system prompts you to re-enter the data. If the provider and recipient data are valid, AVRS returns one or more of the following responses:

- System could not find a claim that matches the search criteria
- Paid amount, checkwrite date, and ICN for paid claims
- Message that the claim is in process for suspended claims
- EOB codes and RA date for claim denials
- Line item number, procedure or revenue code, and EOB code for each denied line item
- Message that claim has been partially refunded and ICN for partially refunded claim
- Message that claim has been fully refunded, and ICN for fully refunded claim

The system also returns similar messages if more than one claim matches the search criteria. Once you have listened to the response, you may choose from the following options, as prompted by AVRS:

- Press 1 to repeat the claim status response
- Press 2 to check another claim for the same recipient
- Press 3 to check a claim for another recipient
- Press 4 to enter another NPI
- Press 9 to return to the Main Menu
- Press 0 to speak with a Provider Assistance representative (please note that the Provider Assistance Center is available during normal business hours only)
- Hang up to end the call

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L.4.4 Verifying Recipient Eligibility

To verify recipient eligibility, press 3 (the number three) from the Main Menu. AVRS prompts you for the following:

- Your NPI or Alabama Medicaid provider number, followed by the pound sign
- A valid Alabama Medicaid recipient number, or the recipient's Social Security Number and Date of Birth, each followed by the pound sign
- Eligibility date, either for the current month (simply press the pound (#) sign) or for a previous month for which you must enter the date in MMCCYY format, followed by the pound sign
- Press 1 to hear all screening types; otherwise press 2
- Patient account number, if applicable (to bypass this, simply press the pound (#) sign)

NOTE:

The patient account number is an optional field. It reflects your internal patient account number. You may find it helpful to enter this number if you wish to receive a fax response and would like the number to display on the response. You may enter a maximum of 15 digits.

AVRS verifies the data you entered (except for the patient account number) and returns a message if the recipient is not eligible for the eligibility dates entered. If the recipient is eligible, you may choose from the following sub-menu options, as prompted by AVRS:

- Press 1 for eligibility information
- Press 2 for benefit limits
- Press 3 for other insurance
- Press 9 to return to the Main Menu
- Press 0 to speak with a Provider Assistance Center representative (please note that the Provider Assistance Center is available during normal business hours only)

L.4.5 General Eligibility Information

You can receive a faxed copy of the eligibility response. Instructions are provided below.

Prior to playing the response, you may choose from the following options, prompted by AVRS:

- Press 1 to receive a fax only response of the eligibility information
- Press 2 to receive a voice only response
- Press 3 if you want both a fax and voice response

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Receiving a Fax

When you select Option 1 or 3, AVRS prompts you to enter your ten-digit fax number (three-digit area code plus the seven-digit number), followed by the pound (#) sign. The system will send a fax transmission to the number you entered.

AVRS provides the following eligibility information for the recipient number entered:

- Check digit for recipient number entered
- Recipient last and first names
- Current recipient number and check digit
- Issue number for recipient ID card
- Recipient date of birth and sex
- Eligibility start and stop dates corresponding to the month of eligibility entered
- Screening information, if selected (Screening information includes both fee-for-service and encounter related if applicable)
- City
- State
- ZIP code
- County code
- Maternity waiver information, if applicable
- Recipient aid category
- Lock-in, lock-out, Long Term Care, and waiver information
- Medicare HMO information and HIC number
- Attributed PCP Provider Information, if applicable
- Managed care information, including plan name, PMP name, phone number, and 24-hour phone number
- ACHN enrollment , if applicable
- Recipient Application Status, if applicable

Once the response has played, you may choose from the following options, prompted by AVRS:

- Press 1 to repeat the message
- Press 2 to speak back service type coverage and patient responsibility
- Press 3 to continue

Selecting Option 2 to speak back service type coverage and patient responsibility

Option 2 speaks back the service type coverage and financial responsibility for the recipient's benefit plan. The copay can be zero, a fixed rate, or include an amount range based on the benefit plan. The table below shows the service types to be spoken back along with an example of amounts for co-insurance, deductible and copay.

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NOTE:

The numbers provided below are examples and not actual minimums or maximums.

Plan	Co-Insurance	Deductible	Copay Minimum	Copay Maximum
Medical Care	0	0	0	50.00
Benefit Plan	0	0	0	50.00
Chiropractic	0	0	0	50.00
Dental	0	0	0	50.00
Hospital	0	0	0	50.00
Hospital-Inpat	0	0	0	50.00
Hospital-Outpat	0	0	0	50.00
Emergency SVC	0	0	0	50.00
Pharmacy	0	0	0	50.00
Physician Off Visit	0	0	0	50.00
Vision	0	0	0	50.00
Mental Health	0	0	0	50.00
Urgent Care	0	0	0	50.00

This information is returned by default on the fax back if fax back is selected. It is shown on the fax back under the 'Eligibility Information' section where the benefit plan information is located. Just below the Aid Category and Description the service types table will be shown as above with the correlating information.

After the service type coverage and patient responsibility is spoken back the following options are given.

- Press 1 to repeat the eligibility information
- Press 2 to continue to hear service type coverage and patient responsibility
- Press 3 to continue

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)

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- Hang up to end the call

If you select Option 1, AVRS allows you to check benefit limits or other insurance for the recipient number you entered.

L.4.6 Benefit Limits

To access benefit limits (option 2 on the sub-menu) (Benefit limits are fee-for-service only) for the recipient number you entered, choose from the following options:

- Press 1 for inpatient, outpatient, and physician counts
- Press 2 for eyeglass limitation counts
- Press 3 for dental limits
- Press 4 for other counts
- Press 5 to repeat the message
- Press 9 to return to the Main Menu
- Press 0 to speak with a Provider Assistance Center representative (please note that the Provider Assistance Center is available during normal business hours only)

If you choose options 1-4, AVRS responds with the applicable limitation information, then prompts you to select from the following:

- Press 1 to repeat the response
- Press 2 to inquire on other limits for the recipient you entered
- Press 3 to continue

If you select Option 3 (to continue), AVRS allows you to request another type of recipient information for the same recipient; check eligibility for another recipient; enter another provider number; return to the Main Menu; speak with a Provider Assistance Center representative; or end the call.

Inpatient, Outpatient, and Physician Counts

AVRS provides the effective date of the limitation counts and the paid and suspended counts for the following limits:

- Inpatient hospital days
- Outpatient hospital days
- Physician office visits

Eyeglass Limitation Counts

AVRS provides the effective date of the limitation counts and the paid and suspended counts for the following limits:

- Eyeglass frames
- Eyeglass lenses
- Eyeglass fitting exams
- Eyeglass exams

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Dental Limitation Counts

When available, AVRS provides the paid and suspended counts for the following limits:

- Space maintainers
- Fluoride
- Prophylaxis
- Full or panoramic X-rays
- Oral exams

Other Counts

AVRS provides the effective date of the limitation counts and the paid and suspended counts for the following limits:

- Home health visits
- Ambulatory surgery center visits
- Dialysis services

Screening Information

AVRS provides the last EPSDT screening date for the following screening types:

- Medical screening
- Dental screening
- Vision screening
- Hearing screening

Please note that EPSDT screenings for recipients under three years of age occur more frequently than yearly. Please refer to Appendix A, EPSDT, for screening schedules.

L.4.7 Other Insurance

AVRS indicates the number of third party policies (option 3 on the sub-menu) on file for the recipient. AVRS will provide the following information for up to three (3) third party policies:

- Policy number
- Company code and group number
- Subscriber name and SSN
- Coverage dates
- Policy coverage information
- Coverage limitation
- Health Insurance Premium (HIP) information

When the response concludes, AVRS provides you with the following options:

- Press 1 to continue researching eligibility, such as benefit limits or other insurance, for the same recipient
- Press 2 to verify eligibility for another recipient
- Press 3 to enter another provider number
- Press 9 to return to the Main Menu

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- Press 0 to speak with a Provider Assistance Center representative (please note that the Provider Assistance Center is available during normal business hours only)
- Hang up to end the call

L.5 Accessing Pricing Information

AVRS allows you to verify pricing information for NDCs and procedure codes.

L.5.1 Drug Pricing

To verify pricing information for drugs, press 4 (the number 4) from the Main Menu. AVRS prompts you for the following:

- Your NPI or Alabama Medicaid provider number, followed by the pound sign
- A valid, 11-digit NDC, followed by the pound sign
- The dispensed date in MMDDCCYY format, followed by the pound sign

AVRS performs a query and responds with the Reimbursement Rate Per Unit (RPU) price on file and whether the NDC requires a prior authorization. The system then allows you to choose from the following options:

- Press 1 to repeat the message
- Press 2 to enter another provider number
- Press 3 to check another NDC for the same provider
- Press 4 to verify the prior authorization number
- Press 9 to return to the Main Menu
- Press 0 to speak with a Provider Assistance Center representative (please note that the Provider Assistance Center is available during normal business hours only)
- Hang up to end the call

L.5.2 Procedure Code Pricing

To verify pricing information for procedure codes, press 5 (the number 5) from the Main Menu. AVRS prompts you for the following:

- Your NPI or Alabama Medicaid provider number, followed by the pound sign
- A valid, five-digit procedure code, followed by the pound sign
- Up to four modifiers, each followed by the pound sign, if applicable (to bypass this, simply press the pound (#) sign)
- The date of service in MMDDCCYY format, followed by the pound sign

AVRS performs a query and responds with the price on file, whether the procedure code requires a prior authorization, and procedure coverage information, if applicable. The system then allows you to choose from the following options:

- Press 1 to repeat the message
- Press 2 to enter another provider number
- Press 3 to check another procedure code for the same provider

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- Press 4 to check another modifier for the same procedure
- Press 9 to return to the Main Menu
- Press 0 to speak with a Provider Assistance Center representative (please note that the Provider Assistance Center is available during normal business hours only)
- Hang up to end the call

L.6 Inquiring About Prior Authorization Information

To inquire about prior authorizations (PAs), press 6 (the number 6) from the main menu. AVRS prompts you for the following:

- Your NPI or Alabama Medicaid provider number, followed by the pound sign
- Recipient's ID or Recipient's Social Security Number
- Date of service (DDMMYYYY)
- The five-digit procedure code or 11-digit NDC, followed by the pound sign
- Up to four modifiers, if inquiring on a PA for a procedure code, each followed by the pound sign, if applicable (to bypass this, simply press the pound (#) sign)

AVRS performs a query and responds with the following information for the PA:

- PA number
- PA status
- Start and stop dates, for approved PAs only
- Units or dollars authorized, for approved PAs only
- Units or dollars used, for approved PAs only

When the response concludes, AVRS provides you with the following options:

- Press 1 to repeat the message
- Press 2 to enter another provider number
- Press 3 to enter another NDC
- Press 4 to enter another procedure code
- Press 5 to enter another modifier
- Press 9 to return to the Main Menu
- Press 0 to speak to a Provider Assistance Center representative

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L.7 Recipient Household Inquiry

To request information about recipient household members, press 7 (the number 7) from the main menu. AVRS prompts you for the following:

- Your NPI or Alabama Medicaid provider number, followed by the pound sign
- The parent/guardian's 12-digit recipient Medicaid number, or the parent/guardian's 9-digit Social Security Number, followed by the pound sign
- The household member's date of birth

You can receive a faxed copy of the household information. Instructions are provided below.

Prior to playing the response, you may choose from the following options, prompted by AVRS:

- Press 1 to receive a fax only response of the household information
- Press 2 to receive a voice only response
- Press 3 if you want both a fax and voice response

Receiving a Fax

When you select Option 1 or 3, AVRS prompts you to enter your ten-digit fax number (three-digit area code plus the seven-digit number), followed by the pound (#) sign. The system will send a fax transmission to the number you entered.

AVRS performs a query and responds with the following information for the household inquiry:

- Member Number
- Member Name
- Member Date of Birth
- Member Race
- Member Sex
- Certifying Program

When the response concludes, AVRS provides you with the following options:

- Press 1 to repeat this member's information
- Press 2 to enter another provider number
- Press 3 to enter a different recipient
- Press 4 to enter another Date of Birth for the same parent/guardian
- Press 9 to return to the Main Menu
- Press 0 to speak with a Provider Assistance Center representative (please note that the Provider Assistance Center is available during normal business hours only)
- Hang up to end the call

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M DMH Medication-Assisted Treatment (MAT)

Medication-assisted treatment (MAT) is the use of medications, in combination with counseling and behavioral therapies to provide a “whole-patient” approach to the treatment of substance use disorders. These services are provided to recipients on the basis of medical necessity.

M.1. Enrollment

For the provision of Substance Abuse Rehabilitative Services an entity:

- Must be an organization that is currently certified by the Alabama Department of Mental Health (DMH) to provide alcohol and other drug treatment services under the provisions of Chapter 580 of the Alabama Administrative Code; and
- Must submit an application to and receive approval by DMH to provide Substance Abuse Rehabilitative Services under the Medicaid Rehabilitative Option program.
- A provider must demonstrate the capacity to provide services off-site in a manner that assures the recipient'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.
- 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 and must have demonstrated the capacity to provide these services.

M.2. Eligible Providers

The eligible practitioners, the qualifications required and services furnished for those who may provide MAT services under the Rehabilitation Option Program are as follows:

- A **physician** licensed under Alabama law to practice medicine or osteopathy; Medical Assessment and Treatment; Intake Evaluation; Individual Counseling; Family Counseling; Group Counseling; Treatment Plan Review; Mental Health and Substance Use Disorders Assessment Update; Psychoeducational Services; Opioid Use Disorder Treatment.
- A **physician assistant** licensed under Alabama law and practicing within the guidelines as outlined by the Alabama Board of Medical Examiners; Medical Assessment and Treatment; Intake Evaluation; Individual Counseling; Family Counseling; Group Counseling;

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Treatment Plan Review; Mental Health and Substance Use Disorders Assessment Update; Psychoeducational Services; Opioid Use Disorder Treatment.

- A **Certified Registered Nurse Practitioner** (CRNP) licensed under Alabama law practicing within the scope as defined by the Joint Committee of the Alabama Board of Nursing and the Alabama Board of Medical Examiners for Advanced Practice Nurses; Medical Assessment and Treatment; Treatment Plan Review; Opioid Use Disorder Treatment.
- A **Certified Registered Psychiatric Nurse Practitioner** (CRNP) licensed under Alabama law practicing within the scope as defined by the Joint Committee of the Alabama Board of Nursing and the Alabama Board of Medical Examiners for Advanced Practice Nurses; Intake Evaluation; Individual Counseling; Family Counseling; Group Counseling; Treatment Plan Review; Mental Health and Substance Use Disorders Assessment Update; Psychoeducational Services; Opioid Use Disorder Treatment.
- A **psychologist** licensed under Alabama law; Intake Evaluation; Individual Counseling; Family Counseling; Group Counseling; Treatment Plan Review; Mental Health and Substance Use Disorders Assessment Update; Psychoeducational Services.
- A **professional counselor** licensed under Alabama law; Intake Evaluation; Individual Counseling; Family Counseling; Group Counseling; Treatment Plan Review; Mental Health and Substance Use Disorders Assessment Update; Psychoeducational Services.
- A **certified social worker** licensed under Alabama law; Intake Evaluation; Individual Counseling; Family Counseling; Group Counseling; Treatment Plan Review; Mental Health and Substance Use Disorders Assessment Update; Psychoeducational Services.
- A **marriage and family** therapist licensed under Alabama law; Intake Evaluation; Individual Counseling; Family Counseling; Group Counseling; Treatment Plan Review; Mental Health and Substance Use Disorders Assessment Update; Psychoeducational Services.
- A **registered nurse** licensed under Alabama law who has completed a master's degree in psychiatric nursing; Intake Evaluation; Opioid Use Disorder Treatment.
- A **registered nurse** licensed under Alabama state law; Psychoeducational Services; Opioid Use Disorder Treatment
- A **practical nurse** licensed under Alabama state law; Opioid Use Disorder Treatment.
- **Qualified Substance Abuse Professional (QSAP) I**: A Qualified Substance Abuse Professional I shall consist of: (i) An individual licensed in the State of Alabama as a: (I) Professional Counselor, Graduate Level Social Worker, Psychiatric Clinical Nurse Specialist, Psychiatric Nurse Practitioner, Marriage and Family Therapist, Clinical Psychologist, Physician's Assistant, Physician; or (ii) An individual who: (I) Has a master's Degree or above from a nationally or regionally accredited university or college in psychology, social work, counseling, psychiatric nursing, and * (II) Has successfully

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completed a clinical practicum or has six month's post master's clinical experience; and * (III) Holds a substance abuse counselor certification credential from the Alabama Association of Addiction Counselors, National Association of Alcoholism and Drug Abuse Counselors, Alabama Alcohol and Drug Abuse Association, or International Certification and Reciprocity Consortium/Alcohol and Other Drug Abuse, Inc. which shall be obtained within thirty (30) months of date of hire. Intake Evaluation.

- **QSAP II** shall consist of: (i) An individual who: (I) Has a Bachelor's Degree from a nationally or regionally accredited university or college in psychology, social work, community-rehabilitation, pastoral counseling, family therapy, or other behavioral health area that requires equivalent clinical course work, and (II) Is licensed in the State of Alabama as a Bachelor Level Social Worker; or (III) Has a Bachelor's Degree from a nationally or regionally accredited college or university in psychology, social work, community-rehabilitation, pastoral counseling, family therapy, or other behavioral health area that requires equivalent clinical course work, and (IV) Holds a substance abuse counselor certification credential from the Alabama Association of Addiction Counselors, National Association of Alcoholism and Drug Abuse Counselors, Alabama Alcohol and Drug Abuse Association, or International Certification and Reciprocity Consortium. Individual Counseling; Family Counseling; Group Counseling.
- **QSAP III** shall consist of: (i) An individual who: (I) Has a Bachelor's Degree from a nationally or regionally accredited university or college in psychology, social work, community-rehabilitation, pastoral counseling, family therapy, or other behavioral health area that requires equivalent clinical course work, and (II) Participates in ongoing supervision by a certified or licensed QSAP I for a minimum of one (1) hour individual per week until attainment of a substance abuse counselor certification credential from the Alabama Association of Addiction Counselors, National Association of Alcoholism and Drug Abuse Counselors, or Alabama Alcohol and Drug Abuse Association, or International Certification and Reciprocity Consortium/Alcohol and Other Drug Abuse, Inc. which shall be obtained within thirty (30) months of hire; Psychoeducational Services.
- Certified Recovery Support Specialist (CRSS) must meet the following minimum qualifications: (i) Certified by ADMH as a Certified Recovery Support Specialist (CRSS) within six (6) months of date of hire, (ii) and has 2 years verified lived experience and (iii) Concurrent participation in clinical supervision by a licensed or certified QSAP I; Peer Support Services

M.3. Covered Services

Intake Evaluation (90791-HF)

Initial clinical evaluation of the recipient's request for assistance. Substance abuse recipients undergo standardized psychosocial assessment. The intake evaluation presents psychological and social functioning, recipient's reported physical and medical condition, the need for additional evaluation and/or

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treatment, and the recipient's fitness for Medication Assisted Treatment (MAT) services.

Billing Unit:	Episode
Maximum Units:	Unlimited
Billing Restrictions:	May not be billed in combination with Treatment Plan Review (H0032)

Medical Assessment and Treatment (H0004-HF)

Face-to-face contact with a recipient during which a qualified practitioner provides psychotherapy and/or medical management services. Services may include physical examinations, evaluation of co-morbid medical conditions, development or management of medication regimens, the provision of insight oriented, behavior modifying, supportive, or interactive psychotherapeutic services, or the provision of educational services related to management of a substance use disorder.

Billing Unit:	15 minutes
Maximum Units:	6 per day, 52 per year
Billing Restrictions:	May not be billed in combination with Partial Hospitalization (H0035), Outpatient Detoxification – Ambulatory Detoxification With Extended On-Site Monitoring (II-D) (H0013), Outpatient Detoxification – Ambulatory Detoxification Without Extended On-Site Monitoring (I-D) (H0014).

Individual Counseling (90832-HF/90834-HF/90837-HF)

The utilization of professional skills by a qualified practitioner to assist a recipient in face-to-face, one-to-one psychotherapeutic encounter in achieving specific objectives of treatment or care for a mental health and/or a substance use disorder. Services are generally directed toward alleviating maladaptive functioning and emotional disturbances relative to a mental health and/or substance use disorder, and restoration of the individual to a level of functioning capable of supporting and sustaining recovery. Individual Counseling may consist of insight oriented, behavior modifying, supportive, or interactive psychotherapeutic services.

Billing Unit:	1 unit
Maximum Unit:	1 per day, 52 per year
Billing Restrictions:	May not be billed in combination with Partial Hospitalization (H0035), Opioid Use Disorder Treatment (H0020), Outpatient Detoxification – Ambulatory Detoxification With Extended On-Site

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Monitoring (II-D) (H0013), Outpatient Detoxification – Ambulatory Detoxification Without Extended On-Site Monitoring (I-D) (H0014).

Additional Information: Billing = 1 of the following codes:
- Code 90832 = therapy given for 16 to 37 minutes
- Code 90834 = therapy given for 38 to 52 minutes
- Code 90837 = therapy given for 53 minutes or greater

Family Counseling 90846-HF (without patient present)/ 90847-HF (with patient present)/ 90849-HF (multiple family group)

A recipient focused intervention that may include the recipient, his/her collateral* and a qualified practitioner. This service is designed to maximize strengths and to reduce behavior problems and/or functional deficits stemming from the existence of a mental health and/or substance use disorder that interferes with the recipient's personal, familial, vocational, and/or community functioning. *Family counseling that involves the participation of a non-Medicaid eligible is for the direct benefit of the beneficiary. The service must actively involve the beneficiary in the sense of being tailored to the beneficiary's individual needs. There may be times when, based on clinical judgment, the beneficiary is not present during the delivery of the service, but remains the focus of the service.*

Billing Unit:	1 episode=minimum of 60 minutes (90846-HF/ 90847HF) 1 episode=minimum of 90 minutes (90849-HF)
Maximum Units:	1 episode per day, 104 per year
Billing Restrictions:	May not be billed in combination with Partial Hospitalization (H0035), Opioid Use Disorder Treatment (H0020), Outpatient Detoxification – Ambulatory Detoxification With Extended On-Site Monitoring (II-D) (H0013), Outpatient Detoxification – Ambulatory Detoxification Without Extended On-Site Monitoring (I-D) (H0014).

Additional Information:
Family therapy is defined as the treatment of family members as a family unit, rather than an individual patient. When family therapy without the patient present (90846) or family therapy with the patient present (90847) is provided, the session is billed as one service (one family unit), regardless of the number of individuals present at the session.

When a family consists of a Medicaid eligible adult and child(ren) and the therapy is not directed at one specific child, services may be directed to the adult for effective treatment of the family unit to address the adult's issues and impact on the family. If the adult is not eligible and the family therapy is

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directed to the adult and not the child, the service may not be billed using the child's recipient id number and the service must actively involve the beneficiary in the sense of being tailored to the beneficiary's individual needs.

If there is more than one eligible child and no child is exclusively identified as the primary recipient of treatment, then the oldest child's recipient id number must be used for billing purposes. When a specific child is identified as the primary patient of treatment, that child's recipient ID number must be used for billing purposes. A family may be biological, foster, adoptive or other family unit.

A family is not a group and providers may not submit a claim for each eligible person attending the same family therapy session.

All members of the family in attendance for the session will sign/mark the signature log or progress note to document their participation in the session (in addition to the therapist documenting their presence/participation).

Group Counseling (90853-HF)

The utilization of professional skills by a qualified practitioner to assist two or more unrelated recipients in a group setting in achieving specific objectives of treatment or care for a substance use disorder. Services are generally directed toward alleviating maladaptive functioning and behavioral, psychological, and/or emotional disturbances, and utilization of the shared experiences of the group's members to assist in restoration of each participant to a level of functioning capable of supporting and sustaining recovery. Group Counseling may consist of insight oriented, behavior modifying, supportive, or interactive psychotherapeutic service strategies.

Billing Unit:	1 episode=minimum of 90 minutes
Maximum Units:	1 episode per day, 104 per year
Billing Restrictions:	May not be billed in combination with Partial Hospitalization (H0035), Opioid Use Disorder Treatment (H0020), Outpatient Detoxification – Ambulatory Detoxification With Extended On-Site Monitoring (II-D) (H0013), Outpatient Detoxification – Ambulatory Detoxification Without Extended On-Site Monitoring (I-D) (H0014).

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Treatment Plan Review (H0032)

Review and/or revision of a recipient's individualized substance use disorder treatment plan by a qualified practitioner who is not routinely directly involved in providing services to the recipient. This review will evaluate the recipient's progress toward treatment objectives, the appropriateness of services being provided, and the need for a recipient's continued participation in treatment.

Billing Unit:	15 minutes
Maximum Units:	1 event with up to 2 units per quarter, 1 event per day, 8 per year (for DMH-MI providers) 1 event with up to 2 units per quarter, 1 event per day, 8 per year (for DMH-SASD providers)
Billing Restrictions:	None

Substance Use Disorders Update (H0031-HF)

A structured interview process that functions to evaluate a recipient's present level of functioning and/or presenting needs. The assessment is used to establish additional or modify existing diagnoses, establish new or additional goals, assess progress toward goals, and/or to determine the need for continued care, transfer, or discharge.

Billing Unit:	15 minutes
Maximum Units:	8 units per day, 56 units per year
Billing Restrictions:	May not be billed in combination with Intake Evaluation (90791)

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Psychoeducational Services (H2027-HF – Individual; H2027-HQ – Group)
Structured, topic specific educational services provided to assist the recipient and the families* of recipients in understanding the nature of the identified behavioral health substance use disorder, symptoms, management of the disorder, how to help the recipient be supported in the community and to identify strategies to support restoration of the recipient to his/her best possible level of functioning.

Billing Unit: 15 minutes

Maximum Units: 416 units per year

8 per day for services provided to an individual recipient's family

8 per day for services provided to a group of recipients' families

Billing Restrictions: May not be billed in combination with Opioid Use Disorder Treatment (H0020), Outpatient Detoxification – Ambulatory Detoxification With Extended On-Site Monitoring (II-D) (H0013), Outpatient Detoxification – Ambulatory Detoxification Without Extended On-Site Monitoring (I-D) (H0014) and H0035-HF Partial Hospitalization.

Opioid Use Disorder Treatment (H0020: HF - Methadone, H0020: HF:AM – Buprenorphine, J2315: HF - Vivitrol)
The administration of medication, including the use of FDA approved medications for the use of opioid use disorders, to recipients who have a diagnosed opioid use disorder. Medication is administered to support the recipient's efforts to restore adequate functioning in major life areas that have been debilitated as a result of opioid addiction. This service includes medication administration and concurrent related medical and clinical services.

The program must be staffed as specified in current and subsequent revisions of:

(1) State regulations established for this service by the Alabama Department of Mental Health and published in the Alabama Administrative Code; and

(2) Federal regulations established for this service by the Substance Abuse and Mental Health Services Administration

Billing Unit: One day

Maximum Units: 365 per year for H0020 (oral Methadone, Buprenorphine). 1 per month for J2315 (injectable Vivitrol)

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Additional Information:
H0020 may be span-billed by multiplying the appropriate number of units for the month by the daily rate. Benefits are limited to 365 units per year. Please utilize the AM modifier when billing for Buprenorphine. Utilization will be monitored through retrospective reviews.

Peer Support Services H0038 HF: HB (Adult) or HF: HB: HQ (Group)
Peer Support services provides structured, scheduled activities that promote socialization, recovery, self-advocacy, development of natural supports, and maintenance of community living skills, by Certified Recovery Support Specialists. Peer Support service actively engages and empowers an individual and his/her identified supports in leading and directing the design of the service plan and thereby ensures that the plan reflects the needs and preferences of the individual (and family when appropriate) with the goal of active participation in this process. Additionally, this service provides support and coaching interventions to individuals (and family when appropriate) to promote recovery, resiliency and healthy lifestyles and to reduce identifiable and increase healthy behaviors intended to prevent relapse and promote long-term recovery. Peer supports provide effective techniques that focus on the individual's self-management and decision making about healthy choices, which ultimately extend the members' lifespan.

Billing Unit:	15 minutes
Maximum Units:	Limited to 20 units per day (individual) and 8 units per day (group). 2,080 units per year for group services and 2,080 units per year for individual services.
Billing Restrictions:	None

M.4. Requirements for Recipient Intake, Treatment Planning, and Service Documentation

An intake evaluation must be performed for each recipient 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 recipient's, need for MAT services, providers must perform an intake evaluation (utilizing the Standardized Substance Abuse Psychosocial Assessment) based on assessment of the following information:

- Family history
- Educational history
- Relevant medical background
- Employment/vocational history
- Psychological/psychiatric treatment history
- Military service history

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- Legal history
- Alcohol/drug use history
- Mental status examination
- A description of the significant problems that the recipient is experiencing

A written treatment plan (service plan, individualized family service plan, plan of care, etc. must be completed by the fifth face-to-face outpatient services, within ten working days after admission in all day programs or residential program, or within other time limits that may be specified under programs specific requirements. For SA services, the patient, counselor, and licensed staff as noted above must all approve the treatment plan prior to the provision of SA treatment services.

- Identification of the clinical issues that will be the focus of treatment
- Specific services necessary to meet the recipient's needs
- Referrals as appropriate for needed services not provided directly by the agency
- Identification of expected outcomes toward which the recipient and therapist will be working to impact upon the specific clinical issues

Unless clinically contraindicated, the recipient will sign/mark the treatment plan to document the consumer's/recipient's participation in developing and/or revising the plan. If the recipient is under the age of 14 or adjudicated incompetent, the parent/foster parent/legal guardian must sign the treatment plan.

Additional Information:
Services may be provided and billed between the initial intake service and the development of the treatment plan if provided within the allowed timeframe for treatment plan development. Once the treatment plan is developed, service types must be specified in the treatment plan in order to be paid by Medicaid, with the exception of intake evaluation, substance use disorders assessment update, 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 recipient's treatment plan once every three months to determine the recipient's progress toward treatment objectives, the appropriateness of the services furnished, and the need for continued treatment. Providers must document this review in the recipient'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. The treatment plan review must be completed and signed by the appropriate staff in the required time frame in order to continue billing for services.

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.

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M.5. Documentation

Documentation in the recipient's record for each session, service, or activity for which Medicaid reimbursement is requested must comply with any applicable certification or licensure standards and must include the following, at a minimum:

- The identification of the specific services rendered
- The date and the amount of time that the services were rendered (to include the time started and the time ended)
- 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 recipient's progress, or lack thereof, related to each of the identified clinical issues discussed

All entries must be legible and complete and must be signed and dated by the person (identified by name and discipline) who is responsible for ordering, providing, or evaluating the service furnished. The author of each entry must be identified and must sign his or her entry.
Documentation of Medicaid recipients' signatures may be entered on a sign-in log, service receipt, or any other record that can be used to indicate the recipient's signature and the date of service.

Treatment plan review and any non-face-to-face services that can be provided by telephone do not require recipient signatures.

When clinical records are audited, Medicaid will apply the list of required documentation to justify payment. Documentation failing to meet the minimum standards noted above will result in recoupment of payments.

Documentation should not be repetitive (examples include, but are not limited to the following scenarios):

- Progress Notes that look the same for other recipients.
- Progress notes that state the same words day after day with no evidence of progression, maintenance or regression.
- Treatment Plans that look the same for other recipients.
- Treatment Plans with goals and interventions that stay the same and have no progression.
- Progress Notes should not be preprinted or predated with the exception that a group therapy note may have a general section that identifies the participants (i.e. the number of participants, etc.), the topic, and a general description of the session which is copied for each participant. However, each participant must also have individualized documentation relative to his/her specific interaction in the group and how it relates to their treatment plan. The progress note should match the goals on the plan and the plan should match the needs of the recipient. The interventions should be appropriate to meet the goals. There should be clear continuity between the documentation.
- Progress Notes must provide enough detail and explanation to justify the amount of billing.

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Treatment Plan

- The Treatment Plan should not be signed or dated prior to the plan meeting date.

Authentication

- Authors must always compose and sign their own entries (whether handwritten or electronic). An author should never create an entry or sign an entry for someone else or have someone else formulate or sign an entry for them. If utilizing a computer entry system, the program must contain an attestation signature line and time/date entry stamp.
    - If utilizing a computer entry system, there must be a written policy for documentation method in case of computer failure/power outage.

Corrections

- Corrections must be made legally and properly by drawing a line through the entry and making sure that the inaccurate information is still legible. Write “error” by the incorrect entry and initial. Do not obliterate or otherwise alter the original entry by blacking out with marker, using whiteout, or writing over an entry. White Out, Liquid Paper, or any form of correctional fluid or correctional tape is not acceptable on **any** records whether being used as a corrective measure or to individualize an original template or for any other reason.

NOTE:

Please refer to Chapter 105 Sections 105.3 – 105.6 for all other information related to billing of claims.

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N Alabama Medicaid Contact Information

N.1 Important Telephone Numbers for the Alabama Medicaid Agency

Dental Services 1-800-688-7989

Durable Medical Equipment

Administration 1-800-688-7989

Hospital, psychiatric, admission

Children/Adolescent 1-800-688-7989

Geriatric Inpatient 1-800-688-7989

Long Term Care 1-800-688-7989

- Home Health Services
- Hospice Services
- Personal Care (for children under 21 only)
- Private Duty Nursing (for children under 21 only)
- Program of All Inclusive Care for the Elderly (PACE)
- Alabama Community Transition (ACT) Waiver

Medical Services Customer Service 1-800-688-7989

- Adolescent Pregnancy Prevention
- Ambulatory Surgical Centers
- EPSDT (Early and periodic screening, diagnosis, and treatment/Child Health Checkups)
- Eye Care
- Family Planning
- Federally Qualified Health Centers
- Hearing Services
- Hospital Program
- Laboratory Services

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- Mental Health Services
- Physician's Program
- Prenatal Care
- Prenatal Education
- Radiology Services
- Renal Dialysis
- Residential Treatment Facilities
- Rural Health Clinics
- Therapist, in home (for children under 21 only)
- Transplants
- Transportation, air (for children under 21 only)

Nursing Home Care

Admissions/Program Administration 1-800-688-7989

Prior Authorization

For providers..…… 1-800-688-7989

For recipients……..1-800-362-1504

- Durable Medical Equipment
- Eye Care
- Home Health, additional visits (for children under 21 only)
- Inpatient Psychiatric Admissions (for children under 21 only)
- Private Duty Nursing (for children under 21 only)
- Therapies, in home (for children under 21 only)

Clinical Services and Support

For providers ……1-800-688-7989

For recipients……1-800-362-1504

Pharmacy Services (prior approval of drugs)..... 1-800-748-0130

Durable Medical Equipment……1-800-362-1504

Medical Prior Authorization……1-800-362-1504

Drug Rebate…… 1- 334-215-4260

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Radiology Services (prior approval of MRI's, CT and PET scans)...1-888-693-3211

Third Party Division

Health Insurance Updates for last names A-F……334-242-5249

Health Insurance Updates for last names G-L…… 334-353-5773

Health Insurance Updates for last names M-R…… 334-242-5280

Health Insurance Updates for last names S-Z…… 334-242-5254

N.2 General Information

For anyone to call 334-242-5000

For Medicaid recipients only.....1-800-362-1504

For Medicaid providers regarding policies, procedures and/or administrative reviews 1-800-362-1504 for all other information.....1-800-688-7989

N.3 Important Telephone Numbers for Gainwell

Automated Voice Response System (AVRS).....1-800-727-7848

Electronic Media Claims (EMC).....1-800-456-1242

Provider Assistance Center.....1-800-688-7989

Provider Enrollment 1-888-223-3630

Provider Relations Representatives.....1-855-523-9170

Gainwell Operator.....334-215-0111

N.4 Mailing Addresses

Alabama Medicaid Agency .....501 Dexter Avenue
Post Office Box 5624
Montgomery, AL 36103-5624

For mailing claims which require attachments:

Pharmacy, Dental, and UB-04 Claims.....Gainwell

.....Post Office Box 244032

.....Montgomery, AL 36124-4032

CMS-1500 Claims.....Gainwell

.....Post Office Box 244032

.....Montgomery, AL 36124-4032

Inquiries, Provider Enrollment Information, Provider Relations

.....Gainwell

.....Post Office Box 241685

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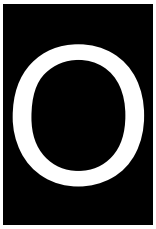
	Montgomery, AL 36124-1685
Medicare-related Claims	Gainwell
	Post Office Box 244032
	Montgomery, AL 36124-4032
Medical Prior Authorization	Gainwell
	Post Office Box 244032
	Montgomery, AL 36124-4032
Pharmacy Prior Authorization	HID
	Post Office Box 3210
	Auburn, AL 36823-3210
	FAX: 1-800-748-0116

N.5 Web Site Address

Refer to the Alabama Medicaid Agency's web site at http://www.medicaid.alabama.gov for the following resources:

- Forms
- Manuals
- Bulletins
- Provider Notices
- Schedule of Events
- Billing and Eligibility Software

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P Durable Medical Equipment (DME) Procedure Codes and Modifiers

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 (837) Institutional electronic claim and the paper claim have been modified to accept up to four Procedure Code Modifiers.

EPSDT Referred Services

The procedure codes identified with an asterisk (*) are available for all Medicaid recipients. However, if these procedure codes exceed Medicaid established limits or program guidelines, a current EPSDT screening, and prior authorization would be required. A prior authorization may be required before Medicaid would make reimbursement for service provided beyond the limitations.

Modifiers

The following modifiers should be added to the five character Healthcare Common Procedure Coding System (HCPCS) code when appropriate:

- **CG – Informational modifier only**

  Used when submitting claims for L0628 for recipients ages 21-65

- **CR - Catastrophe/Disaster Related Replacement**

  Effective February 1, 2012, disaster claims related to fire and theft should be submitted electronically to the Fiscal Agent for processing. Providers must file these claims with the appropriate HCPCS code and Modifier CR. Documentation must accompany prior authorization requests (when needed) for replacement in these instances. The provider must keep all documentation (fire report, theft report, etc.) in the recipient's file. These claims will be monitored by Alabama Medicaid on a quarterly basis.

- **LL - Lease/Rental (applied to purchase)**

  Used when DME equipment rental is to be applied against the purchase price (capped rentals)

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- **RA - Replacement of a DME Item**

  Indicates prior approved (PA) replacement of DME that exceeds the benefit limit.

- **RB - Replacement of a Part of DME Furnished as Part of a Repair (Effective July 1, 2014)**

  Indicates replacement and repair of Durable Medical Equipment (excluding orthotics, prosthetics and assistive communication devices) that is no longer covered by the mandatory one year warranty and meets the Agency's Repair PA exemption requirements.

  Must also accompany procedure code K7039

- **RR - Rental (continuous)**

  Used when DME reimbursed by Alabama Medicaid as a continuous rental

- **U6 - Benefit Limit Override**

  Used to override benefit limit for specified items/supplies. For example, used when dispensing insulin related supplies for insulin dependent recipient with diabetes diagnosis versus non-insulin dependent recipient with no diabetes diagnosis. The benefit limit for each of these categories is listed on the DME Fee Schedule.

- **U8 - Benefit Limit Override**

  Used to override benefit limit for specified items/supplies. The DME Fee Schedule(s) list the applicable procedure codes and benefit limits.

NOTE:

The following procedure codes for the ambulation devices may not be billed at the same time: E0100, E0110, E0112, E0130, E0135, E0135 (RR), E0140, E0143, E0148, E0148 (RR) and E0149.

NOTE:

Include a copy of the Oxygen Certification Form (Form 360) with oxygen requests. Form 360 is used for initial certification, recertification, and changes in the oxygen prescription or order. This form must be filled out, signed and dated by the prescriber if it is being used as the prescription. A DME supplier representative may sign and date the form if the DME provider is submitting both the prescription signed by the prescriber AND Form 360 to Medicaid's fiscal agent for prior authorization review.

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Supplies used with BI-PAP and CPAP Machines

A7030	Full mask fused with positive airway pressure device
A7031	Face mask interface, replacement for full facemask, each
A7032	Replacement cushion for nasal application device, each
A7033	Replacement pillows for nasal application device, pair
A7034	Nasal interface (mask or cannula type) used with positive airway pressure device, without head strap
A7035	Headgear used positive airway pressure device
A7036	Chinstrap used with positive airway pressure device
A7037	Tubing used with positive airway pressure device
A7038	Filter, disposable, used with positive airway pressure device
A7039	Filter, non disposable, used with positive airway pressure device
A7044	Oral interface used with positive airway pressure device, each
A7046	Water chamber for humidifier, used with positive airway pressure device, replacement each

NOTE:

Procedure codes A4362 and A5121 may not be billed on the same date of service as A4414 or A4415. Procedure code A5063 may not be billed on the same date of service as A5052.

External Breast Prosthesis

NOTE:

* Evaluated External Breast Prosthesis on a case-by-case basis with submission of pricing information and medical documentation for procedure codes L8035 and L8039.

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Complex Rehabilitation Technology (CRT) Category Procedure Codes

The related HCPCS billing codes include, but are not limited to:

a. Pure CRT Codes: *These HCPCS codes contain 100% CRT products:*

E0637, E0638, E0986, E1002, E1003, E1004, E1005, E1006, E1007, E1008, E1009, E1010, E1011, E1014, E1037, E1161, E1228, E1229, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, E2209, E2293, E2294, E2300, E2301, E2310, E2311, E2312, E2313, E2321, E2322, E2323, E2324, E2325, E2326, E2327, E2328, E2329, E2330, E2331, E2351, E2373, E2374, E2376, E2377, E2609, E2617, E8000, E8001, E8002, K0005, K0835, K0836, K0837, K0838, K0839, K0840, K0841, K0842, K0843, K0848, K0849, K0850, K0851, K0852, K0853, K0854, K0855, K0856, K0857, K0858, K0859,K0860,K0861, K0862, K0863, K0864, K0868, K0869, K0870, K0871, K0877, K0878, K0879, K0880, K0884, K0885, K0886, K0890, K0891, and K0898.

b. Mixed CRT Codes: *These HCPCS codes contain a mix of CRT products and standard mobility and accessory products: E0143, E0950, E0951, E0952, E0955, E0956, E0957, E0960, E0967, E0978, E0990, E1015, E1016, E1028, E01029, E1030, E2205, E2208, E2231, E2368, E2369, E2370, E2605, E2606, E2607, E2608, E2613, E2614, E2615, E2616, E2620, E2621, E2624, E2625, K0009, K0040, and K0108.*

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NOTE:

To file a claim for procedure codes E1399 or E1399 (EP):

1. The procedure code must be entered on the claim as one line item.

2. The units billed must be entered as “1” unit.

3. The dollar amount billed must be the “total” dollar amount for all items approved on the prior authorization for the date of service on the claim.

In other words, the money amounts for multiple items approved on a prior authorization request for E1399 or E1399 (EP) must be combined and the total money amount must be billed as one lump sum. The total units for all items must be billed as “one” unit.

If each approved item for E1399 or E1399 (EP) is billed on separate lines or if more than one unit is billed, for the same dates of service, the claim will be denied.

Prosthetics, Orthotics and Pedorthics

All orthotics and prosthetics (L Codes) are covered for children up to the age of 21 through the EPSDT Program with a current screening and referral. Most of prosthetic, orthotic and pedorthic codes in this section are covered through the EPSDT Program and do not require prior authorization. The L codes that require an EPSDT Screening and a prior authorization are denoted with two asterisks (**)..

Certain Prosthetic, Orthotic and Pedorthic codes are covered for the adult population ages 21-64. These L codes are denoted with three asterisks (***).. Information regarding medical policy and coverage of these codes for adults can be found in Chapter 14 of the DME Provider Manual.

DME Fee Schedule

The DME Fee Schedule is located on the Alabama Medicaid website and can be accessed by clicking the following link:
http://medicaid.alabama.gov/content/Gated/7.3G_Fee_Schedules.aspx

Call Automated Voice Response System (AVRS) at 1-800- 727-7848 to verify current coverage and reimbursement for each procedure code.

Submit requests to add procedure codes to this list in writing to the Alabama Medicaid Agency, 501 Dexter Avenue, P. O. Box 5624, Montgomery, AL 36103-5624, Attention: DME Program.

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An" X" in the Requires PA column indicates that the procedure requires prior authorization.

Procedure Code	Modifier	Procedure Code Description	RequiresPA
A4206		Syringe With Needle, Sterile 1cc, Each	
A4208*		Syringe With Needle, Sterile 3cc, Each	
A4209		Syringe With Needle, Sterile 5cc Or Greater, Each	
A4210		Needle-Free Injection Device, Each	
A4213*		Syringe, Sterile, 20cc Or Greater, Each	
A4215*		Needle, Sterile, Any Size, Each (Home Iv)	
A4216		Sterile Water, Saline and/or Dextrose (Diluent), 10 ml	
A4217		Sterile Water/Saline, 500 ml	
A4212		Noncoring Needle Or Stylet With Or Without Catheter (Huber Needle)	
A4221		Supplies For Maintenance Of Drug Infusion Catheter, Per Week (List Drug Separately)	
A4222		Infusion Supplies For External Drug Infusion Pump, Per Cassette Or Bag (List Drugs Separately	
A4230		Infusion Set For External Insulin Pump, Nonneedle Cannula Type	
A4232		Syringe With Needle For External Insulin Pump, Sterile, 3cc	
A4233*		Replacement Battery, Alkaline (Other Than J Cell), For Use With Medically Necessary Home Blood Glucose Monitor Owned By Patient, Each	
A4234*		Replacement Battery, Alkaline, J Cell, For Use With Medically Necessary Home Blood Glucose Monitor Owned By Patient, Each	
A4235*		Replacement Battery, Lithium, For Use With Medically Necessary Home Blood Glucose Monitor Owned By Patient, Each	
A4236*		Replacement Batter, Silver Oxide, For Use With Medically Necessary Home Blood Glucose Monitor Owned By Patient, Each	
A4239		Supply Allowance For Non-Adjunctive, Non-Implanted Continuous Glucose Monitor (Cgm), Includes All Supplies And Accessories, 1 Month Supply = 1 Unit Of Service	X
A4244		Alcohol Or Peroxide, Per Pint	
A4245*		Alcohol Wipes, Per Box	
A4246		Betadine Or Phisohex Solution, Per Pint	
A4247*		Betadine Or Iodine Swabs/Wipes, Per Box	
A4250*		Urine Test Or Reagent Strips Or Tablets (100 Tablets Or Strips)	
A4253*		Blood Glucose Test Or Reagent Strips For Home Blood Glucose Monitor, Per 50 Strips	
A4253*	U6	Blood Glucose Test Or Reagent Strips For Home Blood Glucose Monitor, Per 50 Strips	
A4253*	U6	Blood Glucose Test Or Reagent Strips For Home Blood Glucose Monitor, Per 50 Strips	
A4256*		Normal, Low And High Calibrator Solution/Chips	
A4258*		Spring-Powered Device For Lancet, Each	
A4259*		Lancets, Per Box Of 100	

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Procedure Code	Modifier	Procedure Code Description	RequiresPA
A4259	U6	Lancets, Per Box Of 100	
A4259	SC	Lancets, Per Box Of 25	
A4335		Incontinence Supply; Miscellaneous	
A4338*		Indwelling Catheter; Foley Type, Two-Way Latex With Coating (Teflon, Silicone, Silicone Elastomer, Or Hydrophilic, Etc.), Each	
A4340		Indwelling Catheter; Specialty Type, (e.g., Coude, mushroom, wing, etc.), Each	
A4344*		Indwelling Catheter, Foley Type, Two-Way, All Silicone, Each	
A4349*		Male External Catheter, With Or Without Adhesive, Disposable, Each	
A4349*		Male External Catheter, With Or Without Adhesive, Disposable, Each	
A4351*		Intermittent Urinary Catheter; Straight Tip, With Or Without Coating (Teflon, Silicone, Silicone Elastomer, Or Hydrophilic, Etc.), Each	
A4351*		Intermittent Urinary Catheter; Straight Tip, With Or Without Coating (Teflon, Silicone, Silicone Elastomer, Or Hydrophilic, Etc.), Each	
A4352		Intermittent Urinary Catheter; Coude (Curved) Tip, With Or Without Coating (Teflon, Silicone, Silicone Elastomeric, Or Hydrophilic, Etc.), Each	
A4352		Intermittent Urinary Catheter; Coude (Curved) Tip, With Or Without Coating (Teflon, Silicone, Silicone Elastomeric, Or Hydrophilic, Etc.), Each	
A4354*		Insertion Tray With Drainage Bag But Without Catheter	
A4357*		Bedside Drainage Bag, Day Or Night, With Or Without Anti-Reflux Device, With Or Without Tube, Each	
A4358*		Urinary Drainage Bag, Leg Or Abdomen, Vinyl, With Or Without Tube, With Straps, Each	
A4362*		Skin Barrier; Solid, 4 X 4 Or Equivalent; Each	
A4364*		Adhesive, Liquid Or Equal, Any Type, Per Oz	
A4367*		Ostomy Belt, Each	
A4400*		Ostomy Irrigation Set	
A4402*		Lubricant, Per Ounce	
A4404		Ostomy Ring, Each	
A4414*		Ostomy Skin Barrier, With Flange (Solid, Flexible Or Accordion), Without Built-In Convexity, 4 X 4 Inches Or Smaller, Each	
A4415*		Ostomy Skin Barrier, With Flange (Solid, Flexible Or Accordion), Without Built-In Convexity, Larger Than 4x4 Inches, Each	
A4421	SC	Ostomy Supply, Miscellaneous	X
A4450*		Tape, Non-Waterproof, Per 18 Square Inches	
A4452*		Tape, Waterproof, Per 18 Square Inches	
A4456		Adhesive Remover, Wipes, Any Type, Each	
A4606		Oxygen Probe For Use With Oximeter Device, Replacement	X
A4605		Tracheal Suction Catheter, Closed System, Each	
A4614		Peak Expiratory Flow Rate Meter, Hand Held	
A4618		Breathing Circuits	
A4623		Tracheostomy, Inner Cannula	
A4624*		Tracheal Suction Catheter, Any Type Other Than Closed System, Each	

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Procedure Code	Modifier	Procedure Code Description	RequiresPA
A4625		Tracheostomy Care Kit For New Tracheostomy	
A4628*		Oropharyngeal Suction Catheter, Each	
A4629*		Tracheostomy Care Kit For Established Tracheostomy	
A4640		Alternationg Pressure Pad	X
A4927*		Gloves, Non-Sterile, Per 100	
A5052*		Ostomy Pouch, Closed; Without Barrier Attached (1 Piece), Each	
A5054*		Ostomy Pouch, Closed; For Use On Barrier With Flange (2 Piece), Each	
A5061*		Ostomy Pouch, Drainable; With Barrier Attached, (1 Piece), Each	
A5063*		Ostomy Pouch, Drainable; For Use On Barrier With Flange (2 Piece System), Each	
A5071*		Ostomy Pouch, Urinary; With Barrier Attached (1 Piece), Each	
A5120		Skin Barrier, Wipes Or Swaps, Each	
A5121*		Skin Barrier; Solid, 6 X 6 Or Equivalent, Each	
A5500*		Diabetic Fitting (Including Follow-Up) Custom Off The Shelf Shoe (Per Shoe)	
A5500***		Diabetic Fitting (Including Follow-Up) Custom Off The Shelf Shoe (Per Shoe)	
A5501***		Diabetic Custom Molded Shoe, (Per Shoe)	
A5513*		Diabetic Multiple Density Insert, Custom Molded From Patient's Foot, Each	
A5513***		Diabetic Multiple Density Insert, Custom Molded From Patient's Foot, Each	
A6216*		Gauze, Non-Impregnated, Non-Sterile, Pad Size 16 Sq. In. Or Less, Without Adhesive Border, Each Dressing	
A6217*		Gauze, Non-Impregnated, Non-Sterile, Pad Size More Than 16 Sq. In. But Less Than Or Equal To 48 Sq. In., Without Adhesive Border, Each Dressing	
A6222		Guaze, Impregnated With Other Than Water, Normal Saline, Or Hydrogel, Sterile, Pad Size 16 SP IN. Or Less, Without Adhesive Border, Each Dressing	
A6266		Guaze, Impregnated, Other Than Water, Normal Saline, Or Zinc Past, Sterile, Any Width Per Linear Yard	
A6402*		Gauze, Non-Impregnated, Sterile, Pad Size 16 Sq. In. Or Less, Without Adhesive Border, Each Dressing	
A6403*		Gauze, Non-Impregnated, Sterile, Pad Size More Than 16 Sq. In. Less Than Or Equal To 48 Sq. In., Without Adhesive Border, Each Dressing	
A6501		Compress Burn Garment, Bodysuit (Head To Foot), Custom Fabricated	X
A6502		Compression Burn Garment, Chin Strap, Custom Fabricated	X
A6503		Compression Burn Garment, Facial Hood, Custom Fabricated	X
A6504		Compression Burn Garment, Glove To Wrist, Custom Fabricated	X
A6505		Compression Burn Garment, Glove To Elbow, Custom Fabricated	X
A6507		Compression Burn Garment, Foot To Knee Length, Custom Fabricated	X
A6508		Compression Burn Garment, Foot To Thigh Length, Custom Fabricated	X
A6509		Compression Burn Garment, Upper Trunk To Waist Including Arm Openings (Vest), Custom Fabricated	X

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Procedure Code	Modifier	Procedure Code Description	RequiresPA
A6511		Compression Burn Garment, Lower Trunk Including Leg Openings (Pantry), Custom Fabricated	X
A6512		Compression Burn Garment, Not Otherwise Classified	X
A6513		Compression Burn Mask, Face and/or Neck, Plastic Or Equal, Custom Fabricated	X
A6530*		Gradient Compression Stocking, Below Knee, 18-30 mm Hg, Each	
A6531*		Gradient Compression Stocking, Below Knee, 30-40, Each	
A6533*		Gradient Compression Stocking, Thigh Length, 18-30 mm Hg, Each	
A7000		Canister, Disposable, Used With Suction Pump, Each	
A7001		Canister, Non-Disposable, Used With Suction Pump, Each	
A7002		Tubing, Used With Suction Pump, Each	
A7003*		Administration Set, With Small Volume Nonfiltered Pneumatic Nebulizer, Disposable	
A7005*		Administration Set, With Small Volume Nonfiltered Pneumatic Nebulizer, Non-Disposable	
A7008		Large Volume Nebulizer, Disposable, Prefilled, Used With Aerosol Compressor	
A7010		Corrugated Tubing, Disposable, Used With Large Volume Nebulizer, 100 Ft. (Aerosol Tubing)	
A7012		Water Collection Device, Used With Large Volume Nebulizer (Drain Bag)	
A7015		Aerosol Mask, Used With DME Nebulizer	
A7030		Full Face Mask Used With Positive Airway Pressure Device	X
A7031		Face Mask Interface, Replacement For Full Facemask, Each	
A7032		Replacement Cushion For Nasal Application Device, Each	
A7033		Replacement Pillows For Nasal Application Device, Pair	
A7034		Nasal Interface (Mask Or Cannula Type) Used With Positive Airway Pressure Device, Without Head Strap	
A7035		Headgear Used Positive Airway Pressure Device	
A7036		Chinstrap Used With Positive Airway Pressure Device	
A7037		Tubing Used With Positive Airway Pressure Device	
A7038		Filter, Disposable, Used With Positive Airway Pressure Device	
A7039		Filter, Non Disposable , Used With Positive Airway Pressure Device	
A7044		Oral Interface Used With Positive Airway Pressure Device, Each	
A7046		Water Chamber For Humidifier, Used With Positive Airway Pressure Device, Replacement Each	
A7509		Heat Moisture Exchange System Filter Housing, and Adhesive, For Use As A Tracheostomy Heat and Moisture Exchange System, Each	X
A7520		Tracheostomy/Laryngectomy Tube, Non-Cuffed, Polyvinylchloride (PVC), Silicone Or Equal, Each	
A7525		Tracheostomy Mask, Each	
A7526		Tracheostomy Tube Collar/Holder, Each	
A8000		Helmet, Protective, Soft, Prefabricated, Includes All Components And Accessories	X

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Procedure Code	Modifier	Procedure Code Description	RequiresPA
A8001		Helmet, Protective, Hard, Prefabricated, Includes All Components And Accessories	X
A9900		Miscellaneous DME Supply, Accessory, and/or Service Component Of Another HCPC Code (Suction Bacteria Filters)	
B4034		Enteral Feeding Supply Kit; Syringe, Per Day	X
B4035		Enteral Feeding Supply Kit; Pump Fed, Per Day (Covered For Recipients Over 21 Who Meets Medical Criteria, Cannot Tolerate Bolus Feeding And Must Have A Pump.)	X
B4035		Enteral Feeding Supply Kit; Pump Fed, Per Day	X
B4036		Enteral Feeding Supply Kit; Gravity Fed, Per Day	X
B4081*		Nasogastric Tubing With Stylet	
B4082*		Nasogastric Tubing Without Stylet	
B4087		Gastrostomy/Jejunostomy Tube, Standard, Any Material, Any Type, Each	
B4088		Gastrostomy/Jejunostomy Tube, Low Profile, Any Material, Any Type, Each (Covered For Recipients Over 21 Who Meets Medical Criteria, Cannot Tolerate Bolus Feeding And Must Have A Pump.)	X
B4088		Gastrostomy/Jejunostomy Tube, Low Profile, Any Material, Any Type, Each	X
B4220		Parenteral Supply Kit, Premix, Per Day	
B4222		Parenteral Supply Kit, Home Mix, Per Day,	
B4224		Parenteral Nutrition Administration Kit, Per Day	
B9002		Enteral Nutrition Infusion Pump - With Alarm (Per Day) (Covered For Recipients Over 21 Who Meets Medical Criteria, Cannot Tolerate Bolus Feeding And Must Have A Pump	X
B9002	RR	Enteral Nutrition Infusion Pump - With Alarm (Per Day)(Covered For Recipients Over 21 Who Meets Medical Criteria, Cannot Tolerate Bolus Feeding And Must Have A Pump).	X
B9004*	RR	Parenteral Nutrition Infusion Pump, Portable	X
B9006*	RR	Parenteral Nutrition Infusion Pump, Stationary	X
B9998	EP	NOC For Enteral Supplies(Covered For Recipients Over 21 Who Meets Medical Criteria, Cannot Tolerate Bolus Feeding And Must Have A Pump)	X
E0100*		Cane, Includes Canes Of All Materials, Adjustable Or Fixed, With Tip	
E0105*		Cane, Quad Or Three Prong, Includes Canes Of All Materials, Adjustable Or Fixed, With Tips	
E0110*		Crutches, Forearm, Includes Crutches Of Various Materials, Adjustable Or Fixed, Pair, Complete With Tips And Handgrips	
E0112*		Crutches, Underarm, Wood, Adjustable Or Fixed, Pair, With Pads, Tips And Handgrips	
E0114		Crutches, Underarm Other Than Wood, Adjustable Or Fixed, Pair, With Pads, Tips And Handgrips	
E0130*	RR	Walker, Rigid (Pickup), Adjustable Or Fixed Height	
E0130*		Walker, Rigid (Pickup), Adjustable Or Fixed Height	
E0135*	RR	Walker, Folding (Pickup), Adjustable Or Fixed Height	
E0135*		Walker, Folding (Pickup), Adjustable Or Fixed Height	
E0140		Walker, With Trunk Support, Adjustable Or Fixed Height, Any Type	X
E0143		Walker, Folding, Wheeled, Adjustable Or Fixed Height	

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Procedure Code	Modifier	Procedure Code Description	RequiresPA
E0148	RR	Walker, Heavy Duty, Without Wheels, Rigid Or Folding, Any Type, Each	X
E0148		Walker, Heavy Duty, Without Wheels, Rigid Or Folding, Any Type, Each	X
E0149		Walker, Heavy Duty, Wheeled, Rigid Or Folding, Any Type	X
E0153		Platform Attachment, Forearm Crutch, Each	X
E0163*	RR	Commode Chair, Stationary, With Fixed Arms	
E0163*		Commode Chair, Stationary, With Fixed Arms	
E0165*	RR	Commode Chair, Mobile Or Stationary, With Detachable Arms	
E0165*		Commode Chair, Mobile Or Stationary, With Detachable Arms	
E0168*		Commode Chair, Extra Wide and/or Heavy Duty, Stationary Or Mobile, With Or Without Arms, Any Type, Each	X
E0181*	RR	Powered Pressure Reducing Mattress Overlay/Pad, Alternating With Pump Includes Heavy Duty	X
E0181*		Powered Pressure Reducing Mattress Overlay/Pad, Alternating With Pump Includes Heavy Duty	X
E0182		Pump For Alternating Pressure Pad, For Replacement Only	X
E0184	RR	Dry Pressure Mattress	
E0184		Dry Pressure Mattress	
E0185*	RR	Gel Or Gel-Like Pressure Pad For Mattress, Standard Mattress Length and Width	X
E0185*		Gel Or Gel-Like Pressure Pad For Mattress, Standard Mattress Length and Width	X
E0188*	RR	Synthetic Sheepskin Pad	
E0188*		Synthetic Sheepskin Pad	
E0191*		Heel Or Elbow Protector, Each	
E0202	RR	Phototherapy (bilirubin) Light With Photometer	
E0210*	RR	Electric Heat Pad, Standard	
E0210*		Electric Heat Pad, Standard	
E0250*	RR	Hospital Bed, Fixed Height, With Any Type Side Rails, With Mattress	X
E0250*		Hospital Bed, Fixed Height, With Any Type Side Rails, With Mattress	X
E0255*	RR	Hospital Bed, Variable Height, Hi-Lo, With Any Type Side Rails, With Mattress	X
E0255*		Hospital Bed, Variable Height, Hi-Lo, With Any Type Side Rails, With Mattress	X
E0260*	RR	Hospital Bed, Semi-Electric (Head And Foot Adjustment), With Any Type Side Rails, With Mattress	X
E0260*		Hospital Bed, Semi-Electric (Head And Foot Adjustment), With Any Type Side Rails, With Mattress	X
E0271*	RR	Mattress, Innerspring	X
E0271*		Mattress, Innerspring	X
E0275*	RR	Bed Pan, Standard, Metal Or Plastic	
E0275*		Bed Pan, Standard, Metal Or Plastic	
E0276*		Bed Pan, Fracture, Metal Or Plastic	
E0277	RR	Powered Pressure-Reducing Air Mattress	X
E0280	RR	Bed Cradle, Any Type	X
E0280		Bed Cradle, Any Type	X

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Procedure Code	Modifier	Procedure Code Description	RequiresPA
E0303*		Hospital Bed, Heavy Duty, Extra Wide With Weight Capacity Greater Than 350 Pounds, But Less Than 600 Pounds With Any Type Side Rails With Mattress	X
E0304*		Hospital Bed, Extra Heavy Duty, Extra Wide, With Weight Capacity Greater Than 600 Pounds With Any Type Side Rails With Mattress (Invoice)	X
E0310*	RR	Bed Side Rails, Full Length	X
E0310		Bed Side Rails, Full Length	X
E0424*	RR	Stationary Compressed Gaseous Oxygen System, Rental; Includes Container, Contents, Regulator, Flowmeter, Humidifier, Nebulizer, Cannula Or Mask, and Tubing	X
E0431*	RR	Portable Gaseous Oxygen System, Rental; Includes Portable Container, Regulator, Flow Meter, Humidifier, Cannula Or Mask, And Tubing	X
E0441*		Oxygen Contents, Gaseous (For Use With Owned Gaseous Stationary Systems Or When Both A Stationary And Portable Gaseous System Are Owned), 1 Month's Supply = 1	X
E0443		Portable Oxygen Contents, Gaseous (For Use Only With Portable Gaseous Systems When No Stationary Gas Or Liquid System Is Used), 1 Month's Supply = 1 Unit	X
E0445		Oximeter Device For Measuring Blood Oxygen Levels Non-Invasively (Per Overnight Oximetry Encounter)	X
E0445	RR	Oximeter Device For Measuring Blood Oxygen Levels Non-Invasively	X
E0450	RR	Volume Control Ventilator, Without Pressure Support Mode, May Include Pressure Control Mode, Used With Invasive Interface (E.G., Tracheostomy Tube)	X
E0461	RR	Volume Control Ventilator, Without Pressure Support Mode, May Include Pressure Control Mode, Used With Non-Invasive Interface (E.G. Mask)	X
E0463	RR	Pressure Support Ventilator With Volume Control Mode, May Include Pressure Control Mode, Used With Invasive Interface (E.G. Tracheostomy Tube)	X
E0464	RR	Pressure Support Ventilator With Volume Control Mode, May Include Pressure Control Mode, Used With Non-Invasive Interface (e.g.mask)	
E0470	RR	Respiratory Assist Device, Bi-Level Pressure Capability, Without Back-Up Rate Feature, Used With Noninvasive Interface, E.G., Nasal Or Facial Mask	X
E0471	RR	Respiratory Assist Device, Bi-Level Pressure Capability, With Back-Up Rate Feature, Used With Noninvasive Interface, E.G., Nasal Or Facial Mask	X
E0472	RR	Respiratory Assist Device, Bi-Level Pressure Capability, Without Back-Up Rate Feature, Used With Noninvasive Interface, E.G., Tracheostomy Tube (intermittent assist device with continuous positive airway pressure device)	X
E0480		Percussor, Electric Or Pneumatic, Home Model	X
E0482	RR	Cough Stimulating Device, Alternating Positive And Negative Airway Pressure	X
E0483	RR	High Frequency Chest Wall Oscillation Air Pulse Generator System (Includes Hoses And Vest) (Rent To Purchase)	X
E0550	RR	Humidifier, Durable For Extensive Supplemental Humidification During IPPB Treatments Or Oxygen Delivery	X
E0550		Humidifier, Durable For Extensive Supplemental Humidification During IPPB Treatments Or Oxygen Delivery	X
E0561	RR	Humidifier, Non-Heated, Used With Positive Airway Pressure Device	X

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Procedure Code	Modifier	Procedure Code Description	RequiresPA
E0561		Humidifier, Non-Heated, Used With Positive Airway Pressure Device	X
E0562	RR	Humidifier, Heated, Used With Positive Airway Pressure Device	X
E0565	RR	Compressor, Air Power Source For Equipment Which Is Not Self-Contained Or Cylinder Driven	X
E0570*	RR	Nebulizer, With Compressor	
E0570*		Nebulizer, With Compressor	
E0575	RR	Nebulizer, Ultrasonic, Large Volume	X
E0585	RR	Nebulizer With Compressor And Heater	X
E0600*	RR	Respiratory Suction Pump, Home Model, Portable Or Stationary, Electric	X
E0600*		Respiratory Suction Pump, Home Model, Portable Or Stationary, Electric	X
E0601	RR	Continuous Airway Pressure (CPAP) Device	X
E0601	LL	Continuous Airway Pressure (CPAP) Device	X
E0601	RA	Continuous Airway Pressure (CPAP) Device	X
E0607*	RR	Home Blood Glucose Monitor	
E0607*		Home Blood Glucose Monitor	
E0619	RR	Apnea Monitor, With Recording Feature	X
E0621*		Sling Or Seat, Patient Lift, Canvas Or Nylon	
E0630*		Patient Lift, Hydraulic, With Seat Or Sling	X
E0630	RR	Patient Lift, Hydraulic, With Seat Or Sling	X
E0635		Patient Lift, Electric, With Seat Or Sling	X
E0650	RR	Pneumatic Compressor, Non-Segmental Home Model	X
E0650		Pneumatic Compressor, Non-Segmental Home Model	X
E0667	RR	Pneumatic Appliance For Use With Segmental Pneumatic Compressor, Leg	X
E0667		Pneumatic Appliance For Use With Segmental Pneumatic Compressor, Leg	X
E0668	RR	Arm Appliance For Linear Pump	X
E0668		Arm Appliance For Linear Pump	X
E0705*		Transfer Device, Any Type, Each	
E0776*	RR	Iv Pole	
E0776*		Iv Pole	
E0779		Ambulatory Infusion Pump, Mechanical, Reusable, For Infusion 8 Hours Or Greater	X
E0779	RR	Ambulatory Infusion Pump, Mechanical, Reusable, For Infusion 8 Hours Or Greater	X
E0781*	RR	Ambulatory Infusion Pump, Single Or Multiple Channels, Electric Or Battery Operated, With Administrative Equipment, Worn By Patient	X
E0784	RR	External Ambulatory Infusion Pump, Insulin (Rent To Purchase)	X
E0791	RR	Parenteral Infusion Pump, Stationary, Single Or Multi-Channel	X
E0850	RR	Traction Stand, Free Standing, Simple Cervical Traction	X
E0850		Traction Stand, Free Standing, Simple Cervical Traction	X
E0890	RR	Traction Frame, Attached To Footboard, Simple Pelvic Traction	X
E0890		Traction Frame, Attached To Footboard, Simple Pelvic Traction	X
E0910*	RR	Trapeze Bars, A/K/A Patient Helper, Attached To Bed, With Grab Bar	X

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Procedure Code	Modifier	Procedure Code Description	RequiresPA
E0910*		Trapeze Bars, A/K/A Patient Helper, Attached To Bed, With Grab Bar	X
E0911*		Trapeze Bar, Heavy Duty, For Patient Weight Capacity Greater Than 250 Pounds, Attached To Bed, With Grab Bar	X
E0912*		Trapeze Bar, Heavy Duty, For Patient Weight Capacity Greater Than 250 Pounds, Free Standing, Complete With Grab Bar	X
E0944		Pelvic Belt/Harness Boot	X
E0950		Wheelchair Accessory, Tray, Each	X
E0951*		Wheel Loop/Holder, Any Type, With Or Without Ankle Strap, Each	X
E0952		Toe Loop/Holder, Any Type, Each	X
E0955		Wheelchair Accessory, Headrest, Cushioned, Any Type, Including Fixed Mounting Hardware, Each	X
E0956		Wheelchair Accessory, Lateral Trunk Or Hip Support, Any Type, Including Fixed Mounting Hardware, Each	X
E0957		Wheelchair Accessory, Medial Thigh Support, Any Type, Including Fixed Mounting Hardware, Each	X
E0958*		Manual Wheelchair Accessory, One-Arm Drive Attachment, Each	X
E0959		Manual Wheelchair Accessory, Adapter For Amputee, Each	X
E0959		Manual Wheelchair Accessory, Adapter For Amputee, Each	X
E0960		Wheelchair Accessory, Shoulder Harness/Straps Or Chest Strap, Including Any Type Mounting Hardware	X
E0961		Manual Wheelchair Accessory, Wheel Lock Brake Extension (Handle), Each	X
E0966		Manual Wheelchair Accessory, Headrest Extension, Each	X
E0967		Manual Wheelchair Accessory, Hand Rim With Projections, Any Type, Replacement Only, Each	X
E0971*	RR	Manual Wheelchair Accessory, Anti-Tipping Device, Each	X
E0971*		Manual Wheelchair Accessory, Anti-Tipping Device, Each	X
E0973		Wheelchair Accessory, Adjustable Height, Detachable Armrest, Complete Assembly, Each	X
E0974		Manual Wheelchair Accessory, Anti-Rollback Device, Each	X
E0978*		Wheelchair Accessory, Positioning Belt/Safety Belt/Pelvic Strap, Each	X
E0980*		Safety Vest, Wheelchair	X
E0981		Wheelchair Accessory, Seat Upholstery, Replacement Only, Each	X
E0982		Wheelchair Accessory, Back Upholstery, Replacement Only, Each	X
E0983		Manual Wheelchair Accessory, Power Add-On To Convert Manual Wheelchair To Motorized Wheelchair, Joystick Control	X
E0984		Manual Wheelchair Accessory, Power Add-On To Convert Manual Wheelchair To Motorized Wheelchair, Tiller Control	X
E0985		Wheelchair Accessory, Seat Lift Mechanism	X
E0986		Manual Wheelchair Accessory, Push Activated Power Assist, Each	X
E0990		Wheelchair Accessory, Elevating Leg Rest, Complete Assembly, Each	X
E0992		Manual Wheelchair Accessory, Solid Seat Insert	X
E0994		Arm Rest, Each	X
E0995		Wheelchair Accessory, Calf Rest/Pad, Each	X
E1002		Wheelchair Accessory, Power Seating System, Tilt Only	X

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Procedure Code	Modifier	Procedure Code Description	RequiresPA
E1003		Wheelchair Accessory, Power Seating System, Recline Only, Without Shear Reduction	X
E1004		Wheelchair Accessory, Power Seating System, Recline Only, With Mechanical Shear Reduction	X
E1005		Wheelchair Accessory, Power Seating System, Recline Only, With Power Shear Reduction	X
E1006		Wheelchair Accessory, Power Seating System, Combination Tilt And Recline, Without Shear Reduction	X
E1007		Wheelchair Accessory, Power Seating System, Combination Tilt And Recline, With Mechanical Shear Reduction	X
E1008		Wheelchair Accessory, Power Seating System, Combination Tilt And Recline, With Power Shear Reduction	X
E1009		Wheelchair Accessory, Addition To Power Seating System Mechanically Linked Leg Elevation System, Including Pushrod And Leg Rest, Each	X
E1010		Wheelchair Accessory, Addition To Power Seating System, Power Leg Elevation System, Including Leg Rest, Pair	X
E1011		Modification To Pediatric Size Wheelchair, Width Adjustment Package (Not To Be Dispensed With Initial Chair)	X
E1014		Reclining Back, Addition To Pediatric Size Wheelchair	X
E1015		Shock Absorber For Manual Wheelchair, Each	X
E1016		Shock Absorber For Power Wheelchair, Each	X
E1017		Heavy Duty Shock Absorber For Heavy Duty Or Extra Heavy Duty Manual Weelchair, Each	X
E1018		Heavy Duty Shock Absorber For Heavy Duty Or Extra Heavy Duty Power Wheelchair, Each	X
E1020		Residual Limb Support System For Wheelchair	X
E1028*		Wheelchair Accessory, Manual Swingaway, Retractable Or Removable Mounting Hardware For Joystick, Other Control Interface Or Positioning Accessory	X
E1029		Wheelchair Accessory, Ventilator Tray, Fixed	X
E1030		Wheelchair Accessory, Ventilator Tray, Gimbaled	X
E1031	RR	Rollabout Chair, Any And All Types With Castors 5" Or Greater	X
E1031		Rollabout Chair, Any And All Types With Castors 5" Or Greater	X
E1035		Multi-Positional Patient Transfer With Integrated Seat, Operated By Caregiver, Patient Weight Up To And Including 300 Lbs (This Code Is Used To Cover Adaptive Strollers, Equipment And Accessories)	X
E1037*	RR	Transport Chair, Pediatric Size	X
E1037*		Transport Chair, Pediatric Size	X
E1050*	RR	Fully-Reclining Wheelchair, Fixed Full Length Arms, Swing Away Detachable Elevating Leg Rests	X
E1050*		Fully-Reclining Wheelchair, Fixed Full Length Arms, Swing Away Detachable Elevating Leg Rests	X
E1060*	RR	Fully-Reclining Wheelchair, Detachable Arms, Desk Or Full Length, Swing Away Detachable Elevating Legrests	X
E1060*		Fully-Reclining Wheelchair, Detachable Arms, Desk Or Full Length, Swing Away Detachable Elevating Legrests	X
E1070*	RR	Fully-Reclining Wheelchair, Detachable Arms (Desk Or Full Length) Swing Away Detachable Footrest	X

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Procedure Code	Modifier	Procedure Code Description	RequiresPA
E1070*		Fully-Reclining Wheelchair, Detachable Arms (Desk Or Full Length) Swing Away Detachable Footrest	X
E1088*	RR	High Strength Lightweight Wheelchair, Detachable Arms Desk Or Full Length, Swing Away Detachable Elevating Leg Rests	X
E1088*		High Strength Lightweight Wheelchair, Detachable Arms Desk Or Full Length, Swing Away Detachable Elevating Leg Rests	X
E1092	RR	Wide Heavy Duty Wheel Chair, Detachable Arms (Desk Or Full Length), Swing Away Detachable Elevating Leg Rests	X
E1092		Wide Heavy Duty Wheel Chair, Detachable Arms (Desk Or Full Length), Swing Away Detachable Elevating Leg Rests	X
E1093*	RR	Wide Heavy Duty Wheelchair, Detachable Arms Desk Or Full Length Arms, Swing Away Detachable Footrests	X
E1093*		Wide Heavy Duty Wheelchair, Detachable Arms Desk Or Full Length Arms, Swing Away Detachable Footrests	X
E1110*	RR	Semi-Reclining Wheelchair, Detachable Arms (Desk Or Full Length) Elevating Legrests	X
E1110*		Semi-Reclining Wheelchair, Detachable Arms (Desk Or Full Length) Elevating Legrests	X
E1130*	RR	Standard Wheelchair, Fixed Full Length Arms, Fixed Or Swing Away Detachable Footrests	X
E1130*		Standard Wheelchair, Fixed Full Length Arms, Fixed Or Swing Away Detachable Footrests	X
E1140*	RR	Wheelchair, Detachable Arms, Desk Or Full Length, Swing Away Detachable Footrests	X
E1140*		Wheelchair, Detachable Arms, Desk Or Full Length, Swing Away Detachable Footrests	X
E1150*	RR	Wheelchair, Detachable Arms, Desk Or Full Length Swing Away Detachable Elevating Legrests	X
E1150*		Wheelchair, Detachable Arms, Desk Or Full Length Swing Away Detachable Elevating Legrests	X
E1160*	RR	Wheelchair, Fixed Full Length Arms, Swing Away Detachable Elevating Legrests	X
E1160*		Wheelchair, Fixed Full Length Arms, Swing Away Detachable Elevating Legrests	X
E1161		Manual Adult Wheelchair With Tilt N And Space	X
E1180*	RR	Amputee Wheelchair, Detachable Arms (Desk Or Full Length) Swing Away Detachable Footrests	X
E1180*		Amputee Wheelchair, Detachable Arms (Desk Or Full Length) Swing Away Detachable Footrests	X
E1190*	RR	Amputee Wheelchair, Detachable Arms (Desk Or Full Length) Swing Away Detachable Elevating Leg Rests	X
E1190*		Amputee Wheelchair, Detachable Arms (Desk Or Full Length) Swing Away Detachable Elevating Leg Rests	X
E1200*	RR	Amputee Wheelchair, Fixed Full Length Arms, Swing Away Detachable Footrest	X
E1200*		Amputee Wheelchair, Fixed Full Length Arms, Swing Away Detachable Footrest	X
E1225		Wheelchair Accessory, Manual Semi-Reclining Back, (Recline Greater Than 15 Degrees, But Less Than 80 Degrees), Each	X

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Procedure Code	Modifier	Procedure Code Description	RequiresPA
E1226	RR	Wheelchair Accessory, Manual Fully Reclining Back, (Recline Greater Than 80 Degrees), Each	X
E1226		Wheelchair Accessory, Manual Fully Reclining Back, (Recline Greater Than 80 Degrees), Each	X
E1227		Special Height Arms For Wheelchair	X
E1228		Special Back Height For Wheelchair	X
E1229		Wheelchair, Pediatric Size, Not Otherwise Specified	X
E1231		Wheelchair, Pediatric Size, Tilt-In-Space, Rigid, Adjustable, With Seating System	X
E1232		Wheelchair, Pediatric Size, Tilt-In-Space, Folding, Adjustable, With Seating System	X
E1233		Wheelchair, Pediatric Size, Tilt-In-Space, Rigid, Adjustable, Without Seating System	X
E1234		Wheelchair, Pediatric Size, Tilt-In-Space, Folding, Adjustable, Without Seating System	X
E1235		Wheelchair, Pediatric Size, Rigid, Adjustable, With Seating System	X
E1236		Wheelchair, Pediatric Size, Folding, Adjustable, With Seating System	X
E1237	RR	Wheelchair, Pediatric Size, Rigid, Adjustable, Without Seating System	X
E1237		Wheelchair, Pediatric Size, Rigid, Adjustable, Without Seating System	X
E1238	RR	Wheelchair, Pediatric Size, Folding, Adjustable, Without Seating System	X
E1238		Wheelchair, Pediatric Size, Folding, Adjustable, Without Seating System	X
E1240*	RR	Lightweight Wheelchair, Detachable Arms, (Desk Or Full Length) Swing Away Detachable, Elevating Legrest	X
E1240*		Lightweight Wheelchair, Detachable Arms, (Desk Or Full Length) Swing Away Detachable, Elevating Legrest	X
E1260*	RR	Wheelchair Lightweight, Detachable Arms (Desk Or Full Length), Swing Away Detachable Footrest	X
E1260*		Wheelchair Lightweight, Detachable Arms (Desk Or Full Length), Swing Away Detachable Footrest	X
E1280*	RR	Heavy Duty Wheelchair, Detachable Arms (Desk Or Full Length) Elevating Legrests	X
E1280*		Heavy Duty Wheelchair, Detachable Arms (Desk Or Full Length) Elevating Legrests	X
E1285*		Heavy Duty Wheelchair, Fixed Full Length Arms, Swing Away Detachable Footrest	X
E1290*	RR	Heavy Duty Wheelchair, Detachable Arms (Desk Or Full Length) Swing Away Detachable Footrest	X
E1290*		Heavy Duty Wheelchair, Detachable Arms (Desk Or Full Length) Swing Away Detachable Footrest	X
E1296		Special Wheelchair Seat Height From Floor	X
E1297		Special Wheelchair Seat Depth, By Upholstery	X
E1298		Special Wheelchair Seat Depth and/or Width, By Construction	X
E1372	RR	Immersion External Heater For Nebulizer	X
E1390*	RR	Oxygen Concentrator, Single Delivery Port, Capable Of Delivering 85 Percent Or Greater Oxygen Concentration At The Prescribed Flow Rate	X
E1399*		Durable Medical Equipment, Miscellaneous	X
E1811		Static Progressive Stretch Knee Device, Extension and/or Flexion, With Or Without Range Of Motion Adjustment, Includes All Components And Accessories	

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Procedure Code	Modifier	Procedure Code Description	RequiresPA
E2000		Gastric Suction Pump, Home Model, Portable Or Stationary, Electric	X
E2100		Blood Glucose Monitor With Integrated Voice Synthesizer	X
E2103		Non-Adjunctive, Non-Implanted Continuous Glucose Monitor Or Receiver	X
E2201		Manual Wheelchair Accessory, Nonstandard Seat Frame, Width Greater Than Or Equal To 20 Inches And Less Than 24 Inches	X
E2202		Manual Wheelchair Accessory, Nonstandard Seat Frame Width, 24-27 Inches	X
E2203		Manual Wheelchair Accessory, Nonstandard Seat Frame Depth, 20 To Less Than 22 Inches	X
E2204		Manual Wheelchair Accessory, Nonstandard Seat Frame Depth, 22 To 25 Inches	X
E2205		Manual Wheelchair Accessory, Handrim Without Projections, Any Type, Replacement Only, Each	X
E2206		Manual Wheelchair Accessory, Wheel Lock Assembly, Complete, Each	X
E2208		Wheelchair Accessory, Cylinder Tank Carrier, Each	X
E2209		Wheelchair Accessory, Arm Trough, Each	X
E2210		Wheelchair Accessory, Bearings, Any Type, Replacement Only, Each	X
E2211		Manual Wheelchair Accessory, Pneumatic Propulsion Tire, Any Size, Each	X
E2212		Manual Wheelchair Accessory, Tube For Pneumatic Propulsion Tire, Any Size, Each	X
E2213		Manual Wheelchair Accessory, Insert For Pneumatic Propulsion Tire (Removable), Any Type, Any Size, Each	X
E2214		Manual Wheelchair Accessory, Pneumatic Caster Tire, Any Size, Each	X
E2216		Manual Wheelchair Accessory, Foam Filled Propulsion Tire, Any Size, Each	X
E2217		Manual Wheelchair Accessory, Foam Filled Caster Tire, Any Size, Each	X
E2218		Manual Wheelchair Accessory, Foam Propulsion Tire, Any Size, Each	X
E2219		Manual Wheelchair Accessory, Foam Caster Tire, Any Size, Each	X
E2220		Manual Wheelchair Accessory, Solid (Rubber/Plastic) Propulsion Tire, Any Size, Each	X
E2221		Manual Wheelchair Accessory, Solid (Rubber/Plastic) Caster Tire With Integrated Wheel, Any Size, Each	X
E2222		Manual Wheelchair Accessory, Solid (Rubber/Plastic) Caster Tire With Integrated Wheel, Any Size, Each	X
E2223		Manual Wheelchair Accessory, Valve, Any Type, Replacement Only, Each	X
E2224		Manual Wheelchair Accessory, Propulsion Wheel Excludes Tire, Any Size, Each	X
E2225		Manual Wheelchair Accessory, Caster Wheel Excludes Tire, Any Size, Replacement Only, Each	X
E2226		Manual Wheelchair Accessory, Caster Fork, Any Size, Replacement Only, Each	X
E2227		Manual Wheelchair Accessory, Gear Reduction Drive Wheel, Each	X
E2228		Manual Wheelchair Accessory, Wheel Braking System And Lock, Each	X
E2231		Manual Wheelchair Accessory, Solid Seat Support Base (Replaces Sling Seat), Includes Any Type Mounting Hardware	X

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Procedure Code	Modifier	Procedure Code Description	RequiresPA
E2291		Back, Planar, For Pediatric Size Wheelchair Including Fixed Attaching Hardware	X
E2292		Seat, Planar, For Pediatric Size Wheelchair Including Fixed Attaching Hardware	X
E2293		Back, Contoured, For Pediatric Size Wheelchair Including Fixed Attaching Hardware	X
E2294		Seat, Contoured, For Pediatric Size Wheelchair Including Fixed Attaching Hardware	X
E2300		Power Wheelchair Accessory, Power Seat Elevation System	X
E2301		Power Wheelchair Accessory, Power Standing System	X
E2310		Power Wheelchair Accessory, Electronic Connection Between Wheelchair Controller And One Power Seating System Motor, Including All Related Electronics	X
E2311		Power Wheelchair Accessory, Electronic Connection Between Wheelchair Controller And Two Or More Power Seating System Motors, Including All Related Electronics,	X
E2312		Power Wheelchair Accessory, Hand Or Chin Control Interface, Mini-Proportional Remote Joystick, Proportional, Including Fixed Mounting Hardware	X
E2313		Power Wheelchair Accessory, Harness For Upgrade To Expandable Controller, Including All Fastners, Connectors And Mounting Hardware	X
E2321		Power Wheelchair Accessory, Hand Control Interface, Remote Joystick, Nonproportional, Including All Related Electronics, Mechanical Stop Switch, And	X
E2322		Power Wheelchair Accessory, Hand Control Interface, Multiple Mechanical Switches, Nonproportional, Including All Related Electronics, Mechanical Stop	X
E2323		Power Wheelchair Accessory, Specialty Joystick Handle For Hand Control Interface, Prefabricated	X
E2324		Power Wheelchair Accessory, Chin Cup For Chin Control Interface	X
E2325		Power Wheelchair Accessory, Sip And Puff Interface, Nonproportional, Including All Related Electronics, Mechanical Stop Switch, And Manual Swingaway Mounting	X
E2326		Power Wheelchair Accessory, Breath Tube Kit For Sip And Puff Interface	X
E2327		Power Wheelchair Accessory, Head Control Interface, Mechanical, Proportional, Including All Related Electronics, Mechanical Direction Change Switch, And	X
E2328		Power Wheelchair Accessory, Head Control Or Extremity Control Interface, Electronic, Proportional, Including All Related Electronics And Fixed Mounting	X
E2329		Power Wheelchair Accessory, Head Control Interface, Contact Switch Mechanism, Nonproportional, Including All Related Electronics, Mechanical Stop Switch,	X
E2329		Power Wheelchair Accessory, Head Control Interface, Contact Switch Mechanism, Nonproportional, Including All Related Electronics, Mechanical Stop Switch,	X
E2330		Power Wheelchair Accessory, Head Control Interface, Proximity Switch Mechanism, Nonproportional, Including All Related Electronics, Mechanical Stop Switch,	X
E2331		Power Wheelchair Accessory, Attendant Control, Proportional, Including All Related Electronics And Fixed Mounting Hardware	X
E2340		Power Wheelchair Accessory, Nonstandard Seat Frame Width, 20-23 Inches	X

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Procedure Code	Modifier	Procedure Code Description	RequiresPA
E2340		Power Wheelchair Accessory, Nonstandard Seat Frame Width, 20-23 Inches	X
E2341		Power Wheelchair Accessory, Nonstandard Seat Frame Width, 24-27 Inches	X
E2342		Power Wheelchair Accessory, Nonstandard Seat Frame Depth, 20 Or 21 Inches	X
E2343		Power Wheelchair Accessory, Nonstandard Seat Frame Depth, 22-25 Inches	X
E2351		Power Wheelchair Accessory, Electronic Interface To Operate Speech Generating Device Using Power Wheelchair Control Interface	X
E2359		Power Wheelchair Accessory, Group 34 Sealed Lead Acid Battery, Each (E.G. Gel Cell, Absorbed Glassmat)	X
E2360		Power Wheelchair Accessory, 22 Nf Non-Sealed Lead Acid Battery, Each	X
E2361		Power Wheelchair Accessory, 22nf Sealed Lead Acid Battery, Each, (E.G. Gel Cell, Absorbed Glassmat)	X
E2362		Power Wheelchair Accessory, Group 24 Non-Sealed Lead Acid Battery, Each	X
E2363		Power Wheelchair Accessory, Group 24 Sealed Lead Acid Battery, Each (E.G. Gel Cell, Absorbed Glassmat)	X
E2364		Power Wheelchair Accessory, U-1 Non-Sealed Lead Acid Battery, Each	X
E2365		Power Wheelchair Accessory, U-1 Sealed Lead Acid Battery, Each (E.G. Gel Cell, Absorbed Glassmat)	X
E2365	SC	Power Wheelchair Accessory, U-1 Sealed Lead Acid Battery, Each (E.G. Gel Cell, Absorbed Glassmat)	X
E2366		Power Wheelchair Accessory, Battery Charger, Single Mode, For Use With Only One Battery Type, Sealed Or Non-Sealed, Each	X
E2367		Power Wheelchair Accessory, Battery Charger, Dual Mode, For Use With Either Battery Type, Sealed Or Non-Sealed, Each	X
E2368		Power Wheelchair Component, Motor, Replacement Only	X
E2369		Power Wheelchair Component, Gear Box, Replacement Only	X
E2370		Power Wheelchair Component, Motor And Gear Box Combination, Replacement Only	X
E2371		Power Wheelchair Accessory, Group 27 Sealed Lead Acid Battery, (E.G. Gel Cell, Absorbed Glassmat), Each	X
E2372		Power Wheelchair Accessory, Group 27 Non-Sealed Leaad Acid Battery, Each	X
E2373		Power Wheelchair Accessory, Hand Or Chin Control Interface, Mini-Proportional, Compact, Or Short Throw Remote Joystick Or Touchpad, Proportional Including All Related Electronics And Fixed Mounting Hardware.	X
E2374		Power Wheelchair Accessory, Hand Or Chin Control Interface, Standard Remote Joystick (Not Including Controller), Proportional, Including All Related	X
E2375		Power Wheelchair Accessory, Non-Expandable Controller, Including All Related Electronics And Mounting Hardware, Replacement Only	X
E2376		Power Wheelchair Accessory, Expandable Controller, Including All Related Electronics And Mounting Hardware, Replacement Only	X
E2377		Power Wheelchair Accessory, Expandable Controller, Including All Related Electronics And Mounting Hardware, Upgrade Provided At Initial Issue	X
E2381		Power Wheelchair Accessory, Pneumatic Drive Wheel Tire, Any Size, Replacement Only, Each	X

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Procedure Code	Modifier	Procedure Code Description	RequiresPA
E2382		Power Wheelchair Accessory, Tube For Pneumatic Drive Wheel Tire, Any Size, Replacement Only, Each	X
E2383		Power Wheelchair Accessory, Insert For Pneumatic Drive Wheel Tire, (Removable), Any Type, Any Size, Replacement Only, Each	X
E2384		Power Wheelchair Accessory, Pneumatic Caster Tire, Any Size, Replacement Only, Each	X
E2385		Power Wheelchair Accessory, Tube For Pneumatic Caster Tire, Any Size, Replacement Only, Each	X
E2386		Power Wheelchair Accessory, Foam Filled Drive Wheel Tire, Any Size, Replacement Only, Each	X
E2387		Power Wheelchair Accessory, Foam Filled Caster Tire, Any Size, Replacement Only, Each	X
E2388		Power Wheelchair Accessory, Foam Drive Wheel Tire, Any Size, Replacement Only, Each	X
E2389		Power Wheelchair Accessory, Foam Caster Tire, Any Size, Replacement Only, Each	X
E2390		Power Wheelchair Accessory, Solid (Rubber/Plastic) Drive Wheel Tire, Any Size, Replacement Only, Each	X
E2391		Power Wheelchair Accessory, Solid (Rubber/Plastic) Caster Tire (Removable), Any Size, Replacement Only, Each	X
E2392		Power Wheelchair Accessory, Solid (Rubber/Plastic) Caster Tire With Integrated Wheel, Any Size, Replacement Only	X
E2394		Power Wheelchair, Accessory, Drive Wheel, Excludes Tire, Any Size, Replacement Only, Each	X
E2395		Power Wheelchair Accessory, Caster Wheel Excludes Tire, Any Size, Replacement Only, Each	X
E2396		Power Wheelchair Accessory, Caster Fork, Any Size, Replacement Only, Each	X
E2397		Power Wheelchair Accessory, Lithium-Based Battery,Each	X
E2500		Speech Generating Device, Digitized Speech, Using Pre-Recorded Messages, Less Than Or Equal To 8 Minutes Recording Time	X
E2502		Speech Generating Device, Digitized Speech, Using Pre-Recorded Messages, Greater Than 8 Minutes But Less Than Or Equal To 20 Minutes Recording Time	X
E2504		Speech Generating Device, Digitized Speech, Using Pre-Recorded Messages, Greater Than 20 Minutes But Less Than Or Equal To 40 Minutes Recording Time	X
E2506		Speech Generating Device, Digitized Speech, Using Pre-Recorded Messages, Greater Than 40 Minutes Recording Time	X
E2508		Speech Generating Device, Synthesized Speech, Requiring Message Formulation By Spelling And Access By Physical Contact With The Device	X
E2510	RR	Speech Generating Device, Synthesized Speech, Permitting Multiple Methods Of Message Formulation And Multiple Methods Of Device Access	X
E2510		Speech Generating Device, Synthesized Speech, Permitting Multiple Methods Of Message Formulation And Multiple Methods Of Device Access	X
E2511		Speech Generating Software Program, For Personal Computer Or Personal Digital Assistant	X
E2512		Accessory For Speech Generating Device, Mounting System	X
E2599		Accessory For Speech Generating Device, Not Otherwise Classified	X

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Procedure Code	Modifier	Procedure Code Description	RequiresPA
E2601*		General Use Wheelchair Seat Cushion, Width Less Than 22 Inches, Any Depth	X
E2602*		General Use Wheelchair Seat Cushion, Width 22 Inches Or Greater, Any Depth	X
E2603*		Skin Protection Wheelchair Seat Cushion, Width Less Than 22 Inches, Any Depth	X
E2604*		Skin Protection Wheelchair Seat Cushion, Width Less Than 22 Inches Or Greater, Any Depth	X
E2605		Positioning Wheelchair Seat Cushion, Width Less Than 22 Inches, Any Depth	X
E2606		Positioning Wheelchair Seat Cushion, Width 22 Inches Or Greater, Any Depth	X
E2607		Skin Protection And Positioning Wheelchair Seat Cushion, Width Less Than 22 Inches	X
E2608		Skin Protection And Positioning Wheelchair Seat Cushion, Width 22 Inches Or	X
E2609		Custom Fabricated Wheelchair Seat Cushion, An Size	X
E2611		General Use Wheelchair Back Cushion, Width Less Than 22 Inches, Any Height, Including Any Type Mounting Hardware	X
E2612		General Use Wheelchair Back Cushion, Width 22 Inches Or Greater, Any Height, Including Any Type Mounting Hardware	X
E2613		Positioning Wheelchair Back Cushion, Posterior, Width Less Than 22 Inches, Any Height, Including Any Type Mounting Hardware	X
E2614		Positioning Wheelchair Back Cushion, Posterior, Width 22 Inches Or Greater, Any Height, Including Any Type Mounting Hardware	X
E2615		Positioning Wheelchair Back Cushion, Posterior-Lateral, Width Less Than 22 Inches, Any Height, Including Any Type Mounting Hardware	X
E2616		Positioning Wheelchair Back Cushion, Posterior-Lateral, Width 22 Inches Or Greater, Any Height, Including Any Type Mounting Hardware	X
E2617		Custom Fabricated Wheelchair Back Cushion, Any Size, Including Any Type Mounting System	X
E2619		Replacement Cover For Wheelchair Seat Cushion Or Back Cushion, Each	X
E2620		Positioning Wheelchair Back Cushion, Planar Back With Lateral Supports, Width Less Than 22 Inches, Any Height, Including Any Type Mounting Hardware	X
E2621		Positioning Wheelchair Back Cushion, Planar Back With Lateral Supports, Width 22 Inches Or Greater, Any Height, Including Any Type Mounting Hardware	X
E2622		Skin Protection Wheelchair Seat Cushion, Adjustable, Width Less Than 22 Inches, Any Depth	X
E2623		Ski N Protection Wheelchair Seat Cushion, Adjustable, Width, 22 Inches Or Greater, Any Depth	X
E2624		Ski N Protection And Positioning Wheelchair Seat Cushion, Adjustable, Width Less Than 22 Inches , Any Depth	X
E2625		Ski N Protection And Positioning Wheelchair Seat Cushion, Adjustable, Width 22 Inches Or Greater, Any Depth	X
E2626*		Wheelchair Accessory, Shoulder Elbow Orthosis, Mobile Arm Support Attached To Wheelchair, Balanced, Adjustable, Prefabricated, Includes Fitting And Adjustment	X

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Procedure Code	Modifier	Procedure Code Description	RequiresPA
E2627*		Wheelchair Accessory, Shoulder Elbow Orthosis, Mobile Arm Support Attached To Wheelchair, Balanced, Adjustable Rancho Type, Prefabricated, Includes Fitting And Adjustment	X
E2628*		Wheelchair Accessory, Shoulder Elbow Orthosis, Mobile Arm Support Attached To Wheelchair, Balanced, Reclining, Prefabricated, Includes Fitting And Adjustment	X
E2629*		Wheelchair Accessory, Shoulder Elbow Orthosis, Mobile Arm Support Attached To Wheelchair, Balanced, Friction Arm Support (Friction Dampening To Proximal And Distal Joints),	X
E2630*		Wheelchair Accessory, Shoulder Elbow Orthosis, Mobile Arm Support, Monosuspension Arm And Hand Support, Overhead Elbow Forearm Hand Sling Support, Yoke Type Suspension	X
E2631*		Wheelchair Accessory, Seo, Addition To Mobile Arm Support, Elevating Proximal Arm	X
E2632*		Wheelchair Accessory, Seo, Addition To Mobile Arm Support, Offset Or Lateral Rocker Arm With Elastic Balance Control	X
E2633*		Wheelchair Accessory, Seo, Addition To Mobile Arm Support, Supinator	X
E8000		Gait Trainer, Pediatric Size, Posterior Support, Includes All Accessories And Components	X
E8001		Gait Trainer, Pediatric Size, Upright Support, Includes All Accessories And Components	X
E8002		Gait Trainer, Pediatric Size, Anterior Support, Includes All Accessories And Components	X
G0249		Provision Of Test Materials And Equipment For Home Inr Monitoring To Patient With Mechanical Heart Valves	X
K0005		Ultralighweight Wheelchair	X
K0005		Ultralighweight Wheelchair	X
K0007*	RR	Extra Heavy Duty Wheelchair	X
K0007*		Extra Heavy Duty Wheelchair	X
K0009		Other Manual Wheelchair Base	X
K0015*		Detachable, Non-Adjustable Height Armrest, Each	X
K0017		Detachable, Adjustable Height Armrest, Base, Each	X
K0018*		Detachable, Adjustable Height Armrest, Upper Portion, Each	X
K0019*		Arm Pad, Each	X
K0020*		Fixed, Adjustable Height Armrest, Pair	X
K0037*		High Mount Flip-Up Footrest, Each	X
K0038*		Leg Strap, Each	X
K0039*		Leg Strap, H Style, Each	X
K0040*		Adjustable Angle Footplate, Each	X
K0041*		Large Size Footplate, Each	X
K0042*		Standard Size Footplate, Each	X
K0043*		Footrest, Lower Extension Tube, Each	X
K0044*		Footrest, Upper Hanger Bracket, Each	X
K0045*		Footrest, Complete Assembly	X
K0046*		Elevating Legrest, Lower Extension Tube, Each	X
K0047*		Elevating Legrest, Upper Hanger Bracket, Each	X
K0050*		Ratchet Assembly	X
K0051*		Cam Release Assembly, Footrest Or Legrest, Each	X

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Procedure Code	Modifier	Procedure Code Description	RequiresPA
K0052*		Swingaway, Detachable Footrests, Each	X
K0053*		Elevating Footrests, Articulating (Telescoping), Each	X
K0053*	RR	Elevating Footrests, Articulating (Telescoping), Each	X
K0056*		Seat Height Less Than 17" Or Equal To Or Greater Than 21" For A High Strength, Lightweight, Or Ultra Lightweight Wheelchair	X
K0065*		Spoke Protectors, Each	X
K0068*		Pneumatic Tire Tube, Each	X
K0069*		Rear Wheel Assembly, Complete, With Solid Tire, Spokes Or Molded, Each	X
K0070*		Rear Wheel Assembly, Complete, With Pneumatic Tire, Spokes Or Molded, Each	X
K0071*		Front Caster Assembly, Complete, With Pneumatic Tire, Each	X
K0072*		Front Caster Assembly, Complete, With Semi-Pneumatic Tire, Each	X
K0073*		Caster Pin Lock, Each	X
K0077*		Front Caster Assembly, Complete, With Solid Tire, Each	X
K0090		Rear Wheel Tire For Power Wheelchair, Any Size, Each	X
K0098		Drive Belt For Power Wheelchair	X
K0105*		Iv Hanger, Each	X
K0108*		Wheelchair Component Or Accessory, Not Otherwise Specified	X
K0195*	RR	Elevating Leg Rests, Pair (For Use With Capped Rental Wheelchair Base)	X
K0195*		Elevating Leg Rests, Pair (For Use With Capped Rental Wheelchair Base)	X
K0462		Temporary Replacement For Patient Owned Equipment Being Repaired, Any Type	X
K0601		Replacement Battery For External Infusion Pump Owned By Patient, Silver Oxide, 1.5 Volt Each	X
K0606	RR	Automatic External Defibrillator, With Integrated Electrocardiogram Analysis, Agrment Type	X
K0730		Controlled Dose Drug Delivery System	
K0733		Power Wheelchair Accessory, 12 To 24 Amp Hour Sealed Lead Acid Battery, Each (E.G., Gel Cell, Absorbed Glassmat)	X
K0739*		Repair(Labor) Or Non Routine Service For Durable Medical Equipment Other Than Oxygen Equipment Requiring The Skill Of A Technician, Labor Component, Per 15 Minutes. Providers Must Continue To Submit Justification When Billing More Than 4 Units. Include All Units Over 4 On The PA Request With Justification For Repairs. The PA Letter Will State The Total Units Approved.	
K0813		Power Wheelchair, Group 1 Standard, Portable, Sling/Solid Seat And Back, Patient Weight Capacity Up To And Including 300 Pounds	X
K0814		Power Wheelchair, Group 1 Standard, Portable, Captains Chair, Patient Weight Capacity Up To And Including 300 Pounds	X
K0815		Power Wheelchair, Group 1 Standard, Sling/Solid Seat And Back, Patient Weight Capacity Up To And Including 300 Pounds	X
K0815		Power Wheelchair, Group 1 Standard, Sling/Solid Seat And Back, Patient Weight Capacity Up To And Including 300 Pounds	X
K0816		Power Wheelchair, Group 1 Standard, Captains Chair, Patient Weight Capacity Up To And Including 300 Pounds	X
K0820		Power Wheelchair, Group 2 Standard, Portable, Sling/Solid Seat/Back, Patient Weight Capacity Up To And Including 300 Pounds	X

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Procedure Code	Modifier	Procedure Code Description	RequiresPA
K0821		Power Wheelchair, Group 2 Standard, Portable, Captains Chair, Patient Weight Capacity Up To And Including 300 Pounds	X
K0822		Power Wheelchair, Group 2 Standard, Sling/Solid Seat/Back, Patient Weight Capacity Up To And Including 300 Pounds	X
K0823		Power Wheelchair, Group 2 Standard, Captains Chair, Patient Weight Capacity Up To And Including 300 Pounds	X
K0824		Power Wheelchair, Group 2 Heavy Duty, Captains Chair, Patient Weight Capacity 301 To 450 Pounds	X
K0825		Power Wheelchair, Group 2 Heavy Duty, Captains Chair, Patient Weight Capacity 301 To 450 Pounds	X
K0826		Power Wheelchair, Group 2 Very Heavy Duty, Sling/Solid Seat Back, Patient Weight Capacity 451 To 600 Pounds	X
K0827		Power Wheelchair, Group 2 Very Heavy Duty, Captains Chair, Patient Weight Capacity 451 To 600 Pounds	X
K0828		Power Wheelchair, Group 2 Extra Heavy Duty, Sling/Solid Seat Back, Patient Weight Capacity 601 Pounds Or More	X
K0829		Power Wheelchair, Group 2 Extra Heavy Duty, Captains Chair, Patient Weight Capacity 601 Pounds Or More	X
K0830		Power Wheelchair, Group 2 Standard, Seat Elevator, Sling/Solid Seat/Back, Patient Weight Capacity Up To And Including 300 Pounds	X
K0831		Power Wheelchair, Group 2 Standard, Seat Elevator, Captains Chair, Patient Weight Capacity Up To And Including 300 Pounds	X
K0835		Power Wheelchair, Group 2 Standard, Single Power Option, Sling/Solid Seat/Back, Patient Weight Capacity Up To And Including 300 Pounds	X
K0836		Power Wheelchair, Group 2 Standard, Single Power Option, Captains Chair, Patient Weight Capacity Up To And Including 300 Pounds	X
K0837		Power Wheelchair, Group 2 Heavy Duty, Single Power Option, Sling/Solid Seat/Back, Patient Weight Capacity 301 To 450 Pounds	X
K0838		Power Wheelchair, Group 2 Heavy Duty, Single Power Option, Captains Chair Patient Weight Capacity 301 To 450 Pounds	X
K0839		Power Wheelchair, Group 2 Very Heavy Duty, Single Power Option, Sling/Back Seat/Solid Patient Weight Capacity 451 To 600 Pounds	X
K0840		Power Wheelchair, Group 2 Heavy Duty, Single Power Option, Sling/Solid Seat Back Patient Weight Capacity 601 Pounds Or More	X
K0841		Power Wheelchair, Group 2 Standard, Multiple Power Option, Sling/Solid Seat/Back, Patient Weight Capacity Up To And Including 300 Pounds	X
K0842		Power Wheelchair, Group 2 Standard, Multiple Power Option, Captains Chair, Patient Weight Capacity Up To And Including 300 Pounds	X
K0843		Power Wheelchair, Group 2 Heavy Duty, Multiple Power Option, Sling/Solid Seat/Back, Patient Weight Capacity 301 To 450 Pounds	X
K0848		Power Wheelchair, Group 3 Standard, Sling/Back, Patient Weight Capacity Up To And Including 300 Pounds	X
K0849		Power Wheelchair, Group 3 Standard, Captains Chair, Patient Weight Capacity Up To And Including 300 Pounds	X
K0850		Power Wheelchair, Group 3 Heavy Duty, Sling/Solid Seat/Back, Patient Weight Capacity 301 To 450 Pounds	X
K0851		Power Wheelchair, Group 3 Heavy Duty, Captains Chair, Patient Weight Capacity 301 To 450 Pounds	X
K0852		Power Wheelchair, Group 3 Very Heavy Duty, Sling/Solid Seat/Back, Patient Weight Capacity 451 To 600 Pounds	X
K0853		Power Wheelchair, Group 3 Very Heavy Duty, Captains Chair Patient Weight Capacity 451 To 600 Pounds	X

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Procedure Code	Modifier	Procedure Code Description	RequiresPA
K0854		Power Wheelchair, Group 3 Extra Heavy Duty, Sling/Solid Seat Back, Patient Weight Capacity 601 Pounds Or More	X
K0855		Power Wheelchair, Group 3 Extra Heavy Duty, Captains Chair Patient Weight Capacity 601 Pounds Or More	X
K0856		Power Wheelchair, Group 3 Standard, Single Power Option, Sling/Solid Seat/Back, Patient Weight Capacity Up To And Including 300 Pounds	X
K0857		Power Wheelchair, Group 3 Standard, Single Power Option, Captains Chair, Patient Weight Capacity Up To And Including 300 Pounds	X
K0858		Power Wheelchair, Group 3 Heavy Duty, Single Power Option, Sling/Solid Seat/Back, Patient Weight Capacity 301 To 450 Pounds	X
K0859		Power Wheelchair, Group 3 Heavy Duty, Single Power Option, Captains Chair Patient Weight Capacity 301 To 450 Pounds	X
K0860		Power Wheelchair, Group 3 Very Heavy Duty, Single Power Option, Sling/Solid Seat/Back Patient Weight Capacity Pounds To 451 To 600 Pounds	X
K0860		Power Wheelchair, Group 3 Very Heavy Duty, Single Power Option, Sling/Solid Seat/Back Patient Weight Capacity Pounds To 451 To 600 Pounds	X
K0861		Power Wheelchair, Group 3 Standard, Multiple Power Option, Sling/Solid Seat/Back, Patient Weight Capacity Up To And Including 300 Pounds	X
K0862		Power Wheelchair, Group 3 Heavy Duty, Multiple Power Option, Sling/Solid Seat/Back, Patient Weight Capacity 451 To 600 Pounds	X
K0863		Power Wheelchair, Group 3 Very Heavy Duty, Multiple Power Option, Sling/Solid Seat/Back, Patient Weight Capacity 451 To 600 Pounds	X
K0864		Power Wheelchair, Group 3 Extra Heavy Duty, Multiple Power Option, Sling/Solid Seat/Back, Patient Weight Capacity 601 Pounds Or More	X
K0868		Power Wheelchair, Group 4 Standard, Sling/Solid Seat/Back, Patient Weight Capacity Up To And Including 300 Pounds	X
K0869		Power Wheelchair, Group 4 Standard, Captains Chair, Patient Weight Capacity Up To And Including 300 Pounds	X
K0870		Power Wheelchair, Group 4 Heavy Duty, Sling/Solid Seat/Back, Patient Weight Capacity 301 To 450 Pounds	X
K0871		Power Wheelchair, Group 4 Very Heavy Duty, Sling/Solid Seat/Back, Patient Weight Capacity 451 To 600 Pounds	X
K0877		Power Wheelchair, Group 4 Standard, Single Power Option, Sling/Solid Seat/Back, Patient Weight Capacity Up To And Including 300 Pounds	X
K0878		Power Wheelchair, Group 4 Standard, Single Power Option, Captains Chair, Patient Weight Capacity Up To And Including 300 Pounds	X
K0879		Power Wheelchair, Group 4 Heavy Duty, Single Power Option, Sling/Solid Seat/Back, Patient Weight Capacity 301 To 450 Pounds	X
K0880		Power Wheelchair, Group 4 Very Heavy Duty, Single Power Option, Sling/Solid Seat/Back, Patient Weight Capacity 451 To 600 Pounds	X
K0884		Power Wheelchair, Group 4 Standard, Multiple Power Option, Sling/Solid Seat/Back, Patient Weight Capacity Up To And Including 300 Pounds	X
K0885		Power Wheelchair, Group 4 Standard, Multiple Power Option, Captains Chair Patient Weight Capacity Up To And Including 300 Pounds	X
K0886		Power Wheelchair, Group 4 Heavy Duty Multiple Power Option, Sling/Solid Seat/Back Patient Weight Capacity 301 To 450 Pounds	X
K0890		Power Wheelchair, Group 5 Pediatric, Single Power Option, Sling/Solid Seat/Back, Patient Weight Capacity Up To And Including 125 Pounds	X
K0891		Power Wheelchair, Group 5 Pediatric, Multiple Power Option, Sling/Solid Seat/Back, Patient Weight Capacity Up To And Including 125 Pounds	X

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Procedure Code	Modifier	Procedure Code Description	RequiresPA
K0898		Power Wheelchair, Not Otherwise Classified	X
L0112		Cranial Cervical Orthosis, Congenital Torticollis Type, With Or Without Soft Interface Material, Adjustable Range Of Motion Joint, Custom Fabricated	
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)	
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	
L0220		Thoracic, Rib Belt, Custom Fabricated	
L0430		Spinal Orthosis, Anterior-Posterior-Lateral Control, With Interface Material, Custom Fitted (Dewall Posture Protector Only)	
L0452		Tlso, Flexible, Provides Trunk Support, Upper Thoracic Region, Produces Intracavitary Pressure To Reduce Load On The Intervertebral Disks With Rigid	
L0456		Tlso, Flexible, Provides Trunk Support, Thoracic Region, Rigid Posterior Panel And Soft Anterior Apron, Extends From The Sacrococcygeal Junction And	
L0458		Tlso, Triplanar Control, Modular Segmented Spinal System, Two Rigid Plastic Shells, Posterior Extends From The Sacrococcygeal Junction And Terminates Just	
L0458***		Tlso, Triplanar Control, Modular Segmented Spinal System, Two Rigid Plastic Shells, Posterior Extends From The Sacrococcygeal Junction And Terminates Just	
L0460		Tlso, Triplanar Control, Modular Segmented Spinal System, Two Rigid Plastic Shells, Posterior Extends From The Sacrococcygeal Junction And Terminates Just	
L0462		Tlso, Triplanar Control, Modular Segmented Spinal System, Three Rigid Plastic Shells, Posterior Extends From The Sacrococcygeal Junction And Terminates Just	
L0464		Tlso, Triplanar Control, Modular Segmented Spinal System, Four Rigid Plastic Shells, Posterior Extends From Sacrococcygeal Junction And Terminates Just	
L0466		Tlso,Sagittal Control, Rigid Posterior Frame	
L0468		Tlso, Sagittal-Coronal Control, Rigid Posterior Frame And Flexible Soft Anterior Apron With Straps, Closures And Padding, Extends From Sacrococcygeal	
L0470		Tlso,Triplanar Control, Rigid Posterior Frame	
L0472		Tlso, Triplanar Control, Hyperextension, Rigid Anterior And Lateral Frame Extends From Symphysis Pubis To Sternal Notch With Two Anterior Components	

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Procedure Code	Modifier	Procedure Code Description	RequiresPA
L0472***		Tlso, Triplanar Control, Hyperextension, Rigid Anterior And Lateral Frame Extends From Symphysis Pubis To Sternal Notch With Two Anterior Components	
L0480		Tlso, Triplanar Control, One Piece Rigid Plastic Shell Without Interface Liner, With Multiple Straps	
L0482		Tlso, Triplanar Control, One Piece Rigid Plastic Shell With Interface Liner, Multiple Straps And Closures, Posterior Extends From Sacrococcygeal Junction	
L0484		Tlso, Triplanar Control, Two Piece Rigid Plastic Shell Without Interface Liner, With Multiple Straps And Closures, Posterior Extends From Sacrococcygeal	
L0486		Tlso, Triplanar Control, Two Piece Rigid Plastic Shell With Interface Liner, Multiple Straps And Closures, Posterior Extends From Sacrococcygeal Junction	
L0486***		Tlso, Triplanar Control, Two Piece Rigid Plastic Shell With Interface Liner, Multiple Straps And Closures, Posterior Extends From Sacrococcygeal Junction	
L0488		Tlso, Triplanar Control, One Piece Rigid Plastic Shell With Interface Liner, Multiple Straps And Closures, Posterior Extends From Sacrococcygeal Junction	
L0490		Tlso, Sagittal-Coronal Control, One Piece Rigid Plastic Shell, With Overlapping Reinforced Anterior, With Multiple Straps And Closures, Posterior Extends From	
L0491		Tlso, Sagittal-Coronal Control, Modular Segmented Spinal System, Two Rigid Plastic Shells, Posterior Extends From The Sacrococcygeal Junction And	
L0492		Tlso, Sagittal-Coronal Control, Modular Segmented Spinal System, Three Rigid Plastic Shells, Posterior Extends From The Sacrococcygeal Junction And	
L5649		Addition To Lower Extremity, Ischial Containment/Narrow M-L socket	
L0622		Sacroiliac Orthosis, Flexible, Provides Pelvic-Sacral Support, Reduces Motion About The Sacroiliac Joint, Includes Straps, Closures, May Include Pendulous	
L0624		Sacroiliac orthosis, provides pelvic-sacral support, with rigid or semi-rigid panels placed over the sacrum and abdomen, reduces motion about the sacroiliac joint, includes straps, closures, may include pendulous abdomen design, custom fabricated	
L0625		Lumber Orthotic, Sagittal Control, With Rigid Posteria Panel(S), Posteria Extends From L-1 To Below L-5 Vertebra, Produces Intracavity Pressure To Reduce Load On The Intervertebral Discs, Includes Straps, Closures, May Include Pendulous Abdomen Design,	
L0626		Lumbar Orthosis, Sagittal Control, With Rigid Posterior Panel(S), Posterior Extends From L-1 To Below L-5 Vertebra, Produces Intracavitary Pressure To	
L0627		Lumbar Orthosis, Sagittal Control, With Rigid Anterior And Posterior Panels, Posterior Extends From L-1 To Below L-5 Vertebra, Produces Intracavitary	
L0628		Lumber-Sacral Orthosis, Flexible, Provides Lumbo-Sacral Support,Posterior Extends From Sacrococcygeal Junction To T-9 Vetebra, Produces Intracavitary Pressure To Reduce Load On Theintervertebral Disc, Includes Straps, Closures. May Include Stays, Shouldetr Straps, Pendulous Abdomen Design, Prefabricated, Includes Fitting And Adjustment	

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Procedure Code	Modifier	Procedure Code Description	RequiresPA
L0628***	CG modifier used for age 21-64	Lumber-Sacral Orthosis, Flexible, Provides Lumbo-Sacral Support,Posterior Extends From Sacrococcygeal Junction To T-9 Vetebra, Produces Intracavitary Pressure To Reduce Load On Theintervertebral Disc, Includes Straps, Closures. May Include Stays, Shouldetr Straps, Pendulous Abdomen Design, Prefabricated, Includes Fitting And Adjustment	
L0629		Lumbar-sacral orthosis, flexible, provides lumbo-sacral support, posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include stays, shoulder straps, pendulous abdomen design, custom fabricated	
L0630		Lumbar-Sacral Orthosis, Sagittal Control, With Rigid Posterior Panel(S), Posterior Extends From Sacrococcygeal Junction To T-9 Vertebra, Produces	
L0630***		Lumbar-Sacral Orthosis, Sagittal Control, With Rigid Posterior Panel(S), Posterior Extends From Sacrococcygeal Junction To T-9 Vertebra, Produces	
L0631		Lumbar-Sacral Orthosis, Sagittal Control, With Rigid Anterior And Posterior Panels, Posterior Extends From Sacrococcygeal Junction To T-9 Vertebra,	
L0632		Lumbar-sacral orthosis, sagittal control, with rigid anterior and posterior panels, posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, custom fabricated	
L0633		Lumbar-Sacral Orthosis, Sagittal-Coronal Control, With Rigid Posterior Frame/Panel(S), Posterior Extends From Sacrococcygeal Junction To T-9 Vertebra,	
L0634		Lumbar-sacral orthosis, sagittal-coronal control, with rigid posterior frame/panel(s), posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panel(s), produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, stays, shoulder straps, pendulous abdomen design, custom fabricated	
L0635		Lumbar-Sacral Orthosis, Sagittal-Coronal Control, Lumbar Flexion, Rigid Posterior Frame/Panel(S), Lateral Articulating Design To Flex The Lumbar Spine,	
L0636		Lumbar Sacral Orthosis, Sagittal-Coronal Control, Lumbar Flexion, Rigid Posterior Frame/Panels, Lateral Articulating Design To Flex The Lumbar Spine,	
L0637		Lumbar-Sacral Orthosis, Sagittal-Coronal Control, With Rigid Anterior And Posterior Frame/Panels, Posterior Extends From Sacrococcygeal Junction To T-9	
L0638		Lumbar-Sacral Orthosis, Sagittal-Coronal Control, With Rigid Anterior And Posterior Frame/Panels, Posterior Extends From Sacrococcygeal Junction To T-9	
L0639		Lumbar-Sacral Orthosis, Sagittal-Coronal Control, Rigid Shell(S)/Panel(S), Posterior Extends From Sacrococcygeal Junction To T-9 Vertebra, Anterior	
L0640		Lumbar-Sacral Orthosis, Sagittal-Coronal Control, Rigid Shell(S)/Panel(S), Posterior Extends From Sacrococcygeal Junction To T-9 Vertebra, Anterior	
L0640***		Lumbar-Sacral Orthosis, Sagittal-Coronal Control, Rigid Shell(S)/Panel(S), Posterior Extends From Sacrococcygeal Junction To T-9 Vertebra, Anterior	
L0700		Cervical-Thoracic-Lumbar-Sacral-Orthoses (Ctlso), Anterior-Posterior-Lateral Control, Molded To Patient Model, (Minerva Type)	

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Procedure Code	Modifier	Procedure Code Description	RequiresPA
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	
L0859		Addition To Halo Procedure, Magnetic Resonance Image Compatible Systems, Rings And Pins, Any Material	
L0861		Addition To Halo Procedure, Replacement Liner/Interface Material	
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 Four (4)	
L0984		Protective Body Sock, Each	
L0984***		Protective Body Sock, Each	
L1000		Cervical-Thoracic-Lumbar-Sacral Orthosis (Ctlso) (Milwaukee), Inclusive Of Furnishing Initial Orthosis, Including Model	
L1001		Cervical thoracic lumbar sacral orthosis immobilizer, infant size, prefabricated, includes fitting and adjustments	
L1005		Tension Based Scoliosis Orthosis And Accessory Pads, Includes Fitting And Adjustment	
L1010		Addition To Cervical-Thoracic-Lumbar-Sacral Orthosis (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	

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Procedure Code	Modifier	Procedure Code Description	RequiresPA
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 Derotation 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	X
L1310**		Other Scoliosis Procedure, Post-Operative Body Jacket	X
L1510		THKAO, standing frame	
L1520**		THKAO, swivel walker (REQUIRES PRIOR AUTHORIZATION)	X
L1600		Hip Orthosis, Abduction Control Of Hip Joints, Flexible, Frejka Type With Cover, Prefabricated, Includes Fitting And Adjustment	
L1610		Hip Orthosis, Abduction Control Of Hip Joints, Flexible, (Frejka Cover Only), Prefabricated, Includes Fitting And Adjustment	
L1620		Hip Orthosis, Abduction Control Of Hip Joints, Flexible, (Pavlik Harness), Prefabricated, Includes Fitting And Adjustment	
L1630		Hip Orthosis, Abduction Control Of Hip Joints, Semi-Flexible (Von Rosen Type), Custom-Fabricated	
L1640		Hip Orthosis, Abduction Control Of Hip Joints, Static, Pelvic Band Or Spreader Bar, Thigh Cuffs, Custom-Fabricated	
L1650		Hip Orthosis, Abduction Control Of Hip Joints, Static, Adjustable, (Ilfled Type), Prefabricated, Includes Fitting And Adjustment	
L1652		Hip Orthosis, Bilateral Thigh Cuffs With Adjustable Abductor Spreader Bar, Adult Size, Prefabricated, Includes Fitting And Adjustment, Any Type	
L1660		Hip Orthosis, Abduction Control Of Hip Joints, Static, Plastic, Prefabricated, Includes Fitting And Adjustment	
L1680		Hip Orthosis, Abduction Control Of Hip Joints, Dynamic, Pelvic Control, Adjustable Hip Motion Control, Thigh Cuffs (Rancho Hip Action Type), Custom	
L1685		Hip Orthosis, Abduction Control Of Hip Joint, Postoperative Hip Abduction Type, Custom Fabricated	
L1686		Hip Orthosis, Abduction Control Of Hip Joint, Postoperative Hip Abduction Type, Prefabricated, Includes Fitting And Adjustment	
L1690		Combination, Bilateral, Lumbo-Sacral, Hip, Femur Orthosis Providing Adduction And Internal Rotation Control, Prefabricated, Includes Fitting And Adjustment	
L1700		Legg Perthes Orthosis, (Toronto Type), Custom-Fabricated	
L1710		Legg Perthes Orthosis, (Newington Type), Custom Fabricated	
L1720		Legg Perthes Orthosis, Trilateral, (Tachdijan Type), Custom-Fabricated	
L1730		Legg Perthes Orthosis, (Scottish Rite Type), Custom-Fabricated	
L1755		Legg Perthes Orthosis, (Patten Bottom Type), Custom-Fabricated	
L1810		Knee Orthosis, Elastic With Joints, Prefabricated, Includes Fitting And Adjustment	

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Procedure Code	Modifier	Procedure Code Description	RequiresPA
L1820		Knee Orthosis, Elastic With Condylar Pads And Joints, With Or Without Patellar Control, Prefabricated, Includes Fitting And Adjustment	
L1830		Knee Orthosis, Immobilizer, Canvas Longitudinal, Prefabricated, Includes Fitting And Adjustment	
L1831		Knee Orthosis, Locking Knee Joint(S), Positional Orthosis, Prefabricated, Includes Fitting And Adjustment	
L1832		Knee Orthosis, Adjustable Knee Joints (Unicentric Or Polycentric), Positional Orthosis, Rigid Support, Prefabricated, Includes Fitting And Adjustment	
L1834		Knee Orthosis, Without Knee Joint, Rigid, Custom-Fabricated	
L1836		Knee Orthosis, Rigid, Without Joint(S), Includes Soft Interface Material, Prefabricated, Includes Fitting And Adjustment	
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		Knee Orthosis, Single Upright, Thigh And Calf, With Adjustable Flexion And Extension Joint (Unicentric Or Polycentric), Medial-Lateral And Rotation	
L1845		Knee Orthosis, Double Upright, Thigh And Calf, With Adjustable Flexion And Extension Joint (Unicentric Or Polycentric), Medial-Lateral And Rotation	
L1846		Knee Orthosis, Double Upright, Thigh And Calf, With Adjustable Flexion And Extension Joint (Unicentric Or Polycentric), Medial-Lateral And Rotation	
L1850		KO, Swedish type	
L1860		KO, modification of supracondylar prosthetic socket, molded to patient model, (SK)	
L1900*		Ankle Foot Orthosis, Spring Wire, Dorsiflexion Assist Calf Band, Custom-Fabricated	
L1902		Ankle Foot Orthosis, Ankle Gauntlet, Prefabricated, Includes Fitting And Adjustment	
L1904		Ankle Foot Orthosis, Molded Ankle Gauntlet, Custom-Fabricated	
L1906		Ankle Foot Orthosis, Multiligamentus Ankle Support, Prefabricated, Includes Fitting And Adjustment	
L1907		Afo, Supramalleolar With Straps, With Or Without Interface/Pads, Custom Fabricated	
L1910		Ankle Foot Orthosis, Posterior, Single Bar, Clasp Attachment To Shoe Counter, Prefabricated, Includes Fitting And Adjustment	
L1920		Ankle Foot Orthosis, Single Upright With Static Or Adjustable Stop (Phelps Or Perlstein Type), Custom-Fabricated	
L1930		Ankle Foot Orthosis, Plastic Or Other Material, Prefabricated, Includes Fitting And Adjustment	
L1930***		Ankle Foot Orthosis, Plastic Or Other Material, Prefabricated, Includes Fitting And Adjustment	
L1932		Afo, Rigid Anterior Tibal Section, Total Carbon Fiber Or Equal Material, Prefabricated, Includes Fitting And Adjustment	
L1940		Ankle Foot Orthosis, Plastic Or Other Material, Custom-Fabricated	
L1945		Ankle Foot Orthosis, Plastic, Rigid Anterior Tibial Section (Floor Reaction), Custom-Fabricated	

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Procedure Code	Modifier	Procedure Code Description	RequiresPA
L1950		Ankle Foot Orthosis, Spiral, (Institute Of Rehabilitative Medicine Type), Plastic, Custom-Fabricated	
L1951		Ankle Foot Orthosis, Spiral, (Institute Of Rehabilitative Medicine Type), Plastic Or Other Material, Prefabricated, Includes Fitting And Adjustment	
L1960		Ankle Foot Orthosis, Posterior Solid Ankle, Plastic, Custom-Fabricated	
L1960***		Ankle Foot Orthosis, Posterior Solid Ankle, Plastic, Custom-Fabricated	
L1970		Ankle Foot Orthosis, Plastic With Ankle Joint, Custom-Fabricated	
L1970***		Ankle Foot Orthosis, Plastic With Ankle Joint, Custom-Fabricated	
L1971		Ankle Foot Orthosis, Plastic Or Other Material With Ankle Joint, Prefabricated, Includes Fitting And Adjustment	
L1980		Ankle Foot Orthosis, Single Upright Free Plantar Dorsiflexion, Solid Stirrup, Calf Band/Cuff (Single Bar 'Bk' Orthosis), Custom-Fabricated	
L1990		Ankle Foot Orthosis, Double Upright Free Plantar Dorsiflexion, Solid Stirrup, Calf Band/Cuff (Double Bar 'Bk' Orthosis), Custom-Fabricated	
L1990***		Ankle Foot Orthosis, Double Upright Free Plantar Dorsiflexion, Solid Stirrup, Calf Band/Cuff (Double Bar 'Bk' Orthosis), Custom-Fabricated	
L2000		Knee Ankle Foot Orthosis, Single Upright, Free Knee, Free Ankle, Solid Stirrup, Thigh And Calf Bands/Cuffs (Single Bar 'Ak' Orthosis), Custom-Fabricated	
L2005		Knee Ankle Foot Orthosis, Any Material, Single Or Double Upright, Stance Control, Automatic Lock And Swing Phase Release, Mechanical Activation,	
L2010		Knee Ankle Foot Orthosis, Single Upright, Free Ankle, Solid Stirrup, Thigh And Calf Bands/Cuffs (Single Bar 'Ak' Orthosis), Without Knee Joint,	
L2020		Knee Ankle Foot Orthosis, Double Upright, Free Ankle, Solid Stirrup, Thigh And Calf Bands/Cuffs (Double Bar 'Ak' Orthosis), Custom-Fabricated	
L2020***		Knee Ankle Foot Orthosis, Double Upright, Free Ankle, Solid Stirrup, Thigh And Calf Bands/Cuffs (Double Bar 'Ak' Orthosis), Custom-Fabricated	
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		Knee Ankle Foot Orthosis, Full Plastic, Double Upright, With Or Without Free Motion Knee, With Or Without Free Motion Ankle, Custom Fabricated	
L2037		Knee Ankle Foot Orthosis, Full Plastic, Single Upright, With Or Without Free Motion Knee, With Or Without Free Motion Ankle, Custom Fabricated	
L2038		Knee Ankle Foot Orthosis, Full Plastic, With Or Without Free Motion Knee, Multi-Axis Ankle, Custom Fabricated	
L2039		Knee Ankle Foot Orthosis, Full Plastic, Single Upright, Poly-Axial Hinge, Medial Lateral Rotation Control, With Or Without Free Motion Ankle, Custom	
L2040		Hip Knee Ankle Foot Orthosis, Torsion Control, Bilateral Rotation Straps, Pelvic Band/Belt, Custom Fabricated	
L2050		Hip Knee Ankle Foot Orthosis, Torsion Control, Bilateral Torsion Cables, Hip Joint, Pelvic Band/Belt, Custom-Fabricated	
L2060		Hip Knee Ankle Foot Orthosis, Torsion Control, Bilateral Torsion Cables, Ball Bearing Hip Joint, Pelvic Band/ Belt, Custom-Fabricated	
L2070		HKAFO, torsion control, unilateral rotation straps, pelvic band/belt	

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Procedure Code	Modifier	Procedure Code Description	RequiresPA
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	
L2106		AFO, fracture orthosis, tibial fracture cast orthosis, thermoplastic type casting material, molded to patient	
L2108		Ankle Foot Orthosis, Fracture Orthosis, Tibial Fracture Cast Orthosis, Custom-Fabricated	
L2112		Ankle Foot Orthosis, Fracture Orthosis, Tibial Fracture Orthosis, Soft, Prefabricated, Includes Fitting And Adjustment	
L2114		Ankle Foot Orthosis, Fracture Orthosis, Tibial Fracture Orthosis, Semi-Rigid, Prefabricated, Includes Fitting And Adjustment	
L2116		Ankle Foot Orthosis, Fracture Orthosis, Tibial Fracture Orthosis, Rigid, Prefabricated, Includes Fitting And Adjustment	
L2126		KAFO, fracture orthosis, femoral fracture cast orthosis, synthetic type casting material, molded to patient	
L2128		Knee Ankle Foot Orthosis, Fracture Orthosis, Femoral Fracture Cast Orthosis, Custom-Fabricated	
L2132		Kafo, Fracture Orthosis, Femoral Fracture Cast Orthosis, Soft, Prefabricated, Includes Fitting And Adjustment	
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	
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	
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	
L2232		Addition To Lower Extremity Orthosis, Rocker Bottom For Total Contact Ankle Foot Orthosis, For Custom Fabricated Orthosis Only	
L2240		Addition to lower extremity, round caliper and plate attachment	
L2250		Addition To Lower Extremity, Foot Plate, Molded To Patient Model, Stirrup Attachment	

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Procedure Code	Modifier	Procedure Code Description	RequiresPA
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/Valgus Correction ('T') Strap, Padded/Lined Or Malleolus Pad	
L2275		Addition To Lower Extremity, Varus/Valgus 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, For Custom Fabricated Orthosis Only	
L2330		Addition To Lower Extremity, Lacer Molded To Patient Model, For Custom Fabricated Orthosis Only	
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' '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	
L2405***		Addition To Knee Joint, Drop Lock, Each	
L2415		Addition To Knee Lock With Integrated Release Mechanism (Bail, Cable, Or Equal), Any Material, 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	
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	

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Procedure Code	Modifier	Procedure Code Description	RequiresPA
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	
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, Reciprocation Hip Joint And	
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, Thigh/Weight Bearing, High Roll Cuff	
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	
L2750		Addition to lower extremity orthosis, plating chrome or nickel, per bar	
L2755		Addition To Lower Extremity Orthosis, High Strength, Lightweight Material, All Hybrid Lamination/Prepreg Composite, Per Segment, For Custom Fabricated	
L2760		Addition To Lower Extremity Orthosis, Extension, Per Extension, Per Bar (For Lineal Adjustment For Growth)	
L2768		Orthotic Side Bar Disconnect Device, Per Bar	
L2770		Addition To Lower Extremity Orthosis, Any Material - 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	
L2795***		Addition To Lower Extremity Orthosis, Knee Control, Full Kneecap	
L2800		Addition To Lower Extremity Orthosis, Knee Control, Knee Cap, Medial Or Lateral Pull, For Use With Custom Fabricated Orthosis Only	
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	
L3000		Foot, Insert, Removable, Molded To Patient Model, 'Ucb' Type, Berkeley Shell, Each	

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Procedure Code	Modifier	Procedure Code Description	RequiresPA
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, Premolded, Longitudinal, Each	
L3050		Foot, Arch Support, Removable, Premolded, Metatarsal, Each	
L3060		Foot, Arch Support, Removable, Premolded, 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	
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 Rotatation Bar, Without Shoes	
L3170		Foot, Plastic, Silicone Or Equal, Heel Stabilizer, Each	
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	
L3210		Orthopedic Footwear, Ladies Shoes, Oxford	
L3211		Surgical Boot, Each, Junior	
L3212		Benesch Boot, Pair, Infant	
L3215		Orthopedic Footwear, Ladies Shoe, Oxford, Each	
L3216		Orthopedic Footwear, Ladies Shoe, Depth Inlay, Each	
L3217		Orthopedic Footwear, Ladies Shoe, Hightop, Depth Inlay, Each	
L3219		Orthopedic Footwear, Mens Shoe, Oxford, Each	
L3221		Orthopedic Footwear, Mens Shoe, Depth Inlay, Each	
L3222		Orthopedic Footwear, Mens Shoe, Hightop, Depth Inlay, 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 Shoe, Depth Inlay, Each	
L3250		Orthopedic footwear, custom molded shoe, removable inner mold, prosthetic shoe, each	
L3251		Foot, shoe molded to patient model, silicone shoe, each	

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Procedure Code	Modifier	Procedure Code Description	RequiresPA
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		Surgical Boot/Shoe, 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	
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, rubber	
L3510		Orthopedic Shoe Addition, Insole, Rubber	
L3520		Miscellaneous shoe addition, insole, felt covered with leather	
L3530		Miscellaneous shoe addition, sole, half	
L3540		Orthopedic 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	

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Procedure Code	Modifier	Procedure Code Description	RequiresPA
L3610		Transfer Of An Orthosis From One Shoe To Another, Caliper Plate, New	
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 Browne Splint (Riveton), Both Shoes	
L3649		Orthopedic Shoe, Modification, Addition Or Transfer, Not Otherwise Specified	
L3650		Shoulder Orthosis, Figure Of Eight Design Abduction Restrainer, Prefabricated, Includes Fitting And Adjustment	
L3660		Shoulder Orthosis, Figure Of Eight Design Abduction Restrainer, Canvas And Webbing, Prefabricated, Includes Fitting And Adjustment	
L3670		Shoulder Orthosis, Acromio/Clavicular (Canvas And Webbing Type), Prefabricated, Includes Fitting And Adjustment	
L3671		Shoulder orthosis, shoulder cap design, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment	
L3675		Shoulder Orthosis, Vest Type Abduction Restrainer, Canvas Webbing Type Or Equal, Prefabricated, Includes Fitting And Adjustment	
L3702		Elbow orthosis, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment	
L3710		Elbow Orthosis, Elastic With Metal Joints, Prefabricated, Includes Fitting And Adjustment	
L3720		EO, double upright, with forearm/arm cuffs, free motion	
L3730		Elbow Orthosis, Double Upright With Forearm/Arm Cuffs, Extension/ Flexion Assist, Custom-Fabricated	
L3740		Elbow Orthosis, Double Upright With Forearm/Arm Cuffs, Adjustable Position Lock With Active Control, Custom-Fabricated	
L3760		Eo,With Adjustable Position Locking Joint(S) Prefabricated, Includes Fitting And Adjustments, Any Type	
L3762		Elbow Orthosis, Rigid, Without Joints, Includes Soft Interface Material, Prefabricated, Includes Fitting And Adjustment	
L3763		Elbow wrist hand orthosis, rigid, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment	
L3764		Elbow wrist hand orthosis, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment	
L3765		Elbow wrist hand finger orthosis, rigid, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment	
L3766		Elbow wrist hand finger orthosis, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment	
L3806		Wrist hand finger orthosis, includes one or more nontorsion joint(s), elastic bands, turnbuckle, may include soft interface material, straps, custom	
L3807		Wrist Hand Finger Orthosis, Without Joint(S), Prefabricated, Includes Fitting And Adjustments, Any Type	
L3807***		Wrist Hand Finger Orthosis, Without Joint(S), Prefabricated, Includes Fitting And Adjustments, Any Type	

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Procedure Code	Modifier	Procedure Code Description	RequiresPA
L3808		Wrist hand finger, orthosis, rigid without joints, may include soft interface material; straps, custom fabricatrd, includes fitting and adjustment	
L3891		Addition To Upper Extremity Joint, Wrist Or Elbow, Concentric Adjustable Torsion Style Mechanism For Custom Frabricated Orthotics Only, Each	
L3900		Wrist Hand Finger Orthosis, Dynamic Flexor Hinge, Reciprocal Wrist Extension/ Flexion, Finger Flexion/Extension, Wrist Or Finger Driven, Custom-Fabricated	
L3901		WHFO, dynamic flexor hinge, reciprocal wrist extension/flexion, finger flexion extension, cable driven	
L3905		Wrist hand orthosis, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment	
L3906		Wrist Hand Orthosis, Without Joints, May Include Soft Interface, Straps, Custom Fabricated, Includes Fitting And Adjustment	
L3908		Wrist Hand Orthosis, Wrist Extension Control Cock-Up, Non Molded, Prefabricated, Includes Fitting And Adjustment	
L3912		Hand Finger Orthosis, Flexion Glove With Elastic Finger Control, Prefabricated, Includes Fitting And Adjustment	
L3913		Hand finger orthosis, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment	
L3915		Wrist Hand Orthosis, Includes Oneor More Nontorsion Joint(S), Elastic Bands , Turnbuckles, May Include Soft Interface, Straps, Prefabricated,Includes Fitting And Adjustment	
L3917		Hand Orthosis, Metacarpal Fracture Orthosis, Prefabricated, Includes Fitting And Adjustment	
L3919		Hand orthosis, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment	
L3921		Hand finger orthosis, includes one or more nontorsion joints, elastic bands, tumbuckles, may include soft interface, straps, sustom fabricated, includes fitting and adjustment	
L3925		Finger Orthosis, Proximal Interphalangeal (Pip), Non Torsion Joint/Spring, Extension/Flexion, May Include Soft Interface Material	
L3929		Hand Finger Orthosis, Includes One Or More Nontorsion Joint(S), Turnbuckles, Elastic Bands/Springs, May Include Soft Interface Material, Straps,Prefabricated,Includes Fitting And Adjustments	
L3931		Wrist Hand Finger Orthosis, Includes One Or More Nortorsion Joint(S) Turnbuckles, Elastic Bands/Springs, May Include Soft Interface Materials, Straps, Prefabricated, Includes Fitting And Adjustment	
L3933		Finger Orthosis, Without Joints, May Include Soft Interface, Custom Fabricated, Includes Fitting And Adjustment	
L3934		Finger Orthosis, Safety Pin, Modified, Prefabricated, Includes Fitting And Adjustment	
L3935		Finger orthosis, nontorsion joint, may include soft interface, custom fabricated, includes fitting and adjustment	
L3936		Wrist Hand Finger Orthosis, Palmer, Prefabricated, Includes Fitting And Adjustment	
L3960		Shoulder Elbow Wrist Hand Orthosis, Abduction Positioning, Airplane Design, Prefabricated, Includes Fitting And Adjustment	
L3961		Shoulder elbow wrist hand orthosis, shoulder cap design, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment	
L3962		SEWHO, abduction positioning, Erbs Palsey design	

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Procedure Code	Modifier	Procedure Code Description	RequiresPA
L3967		Shoulder elbow wrist hand orthosis, abduction positioning (airplane design), thoracic component and support bar, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment	
L3971		Shoulder elbow wrist hand orthosis, shoulder cap design, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment	
L3973		Shoulder elbow wrist hand orthosis, abduction positioning (airplane design), thoracic component and support bar, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustmen.	
L3975		Shoulder elbow wrist hand finger orthosis, shoulder cap design, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment	
L3976		Shoulder elbow wrist hand finger orthosis, abduction positioning (airplane design), thoracic component and support bar, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment	
L3977		Shoulder elbow wrist hand finger orthosis, shoulder cap design, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment	
L3978		Shoulder elbow wrist hand finger orthosis, abduction positioning (airplane design), thoracic component and support bar, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment	
L3980		Upper Extremity Fracture Orthosis, Humeral, Prefabricated, Includes Fitting And Adjustment	
L3982		Upper Extremity Fracture Orthosis, Radius/Ulnar, Prefabricated, Includes Fitting And Adjustment	
L3984		Upper Extremity Fracture Orthosis, Wrist, Prefabricated, Includes Fitting And Adjustment	
L3985		Upper extremity fracture orthosis, forearm, hand with wrist hinge	
L3995		Addition To Upper Extremity Orthosis,Sock,Fracture Or Equal, Each	
L3999		Upper Limb Orthosis, Not Otherwise Specified	X
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	
L4040		Replace molded thigh lacer	
L4045		Replace Non-Molded Thigh Lacer, For Custom Fabricated Orthosis Only	
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	
L4205		Repair Of Orthotic Device, Labor Component, Per 15 Minutes	
L4210		Repair Of Orthotic Device, Repair Or Replace Minor Parts	
L4350		Ankle Control Orthosis, Stirrup Style, Rigid, Includes Any Type Interface (E.G., Pneumatic, Gel), Prefabricated, Includes Fitting And Adjustment	

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Procedure Code	Modifier	Procedure Code Description	RequiresPA
L4360		Walking Boot, Pneumatic, With Or Without Joints, With Or Without Interface Material, Prefabricated, Includes Fitting And Adjustment	
L4370		Pneumatic Full Leg Splint, Prefabricated, Includes Fitting And Adjustment	
L4386		Walking Boot, Non-Pneumatic, With Or Without Joints, With Or Without Interface Material, Prefabricated, Includes Fitting And Adjustment	
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		Static Ankle Foot Orthosis, Including Soft Interface Material, Adjustable For Fit, For Positioning, Pressure Reduction, May Be Used For Minimal Ambulation,	
L4398		Foot Drop Splint, Recumbent Positioning Device, Prefabricated, Includes Fitting And Adjustment	
L5000		Partial Foot, Shoe Insert With Longitudinal Arch, Toe Filler	
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	
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, Sort 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	
L5301		Below Knee, Molded Socket, Shin, SACH Foot, Endoskeletal System	
L5301***		Below Knee, Molded Socket, Shin, SACH Foot, Endoskeletal System	
L5311		Knee disarticulation (or through knee), molded socket, external knee joints, shins, SACH foot, endoskeletal system.	
L5312		Knee Disarticulation (Or Through Knee), Molded Socket, Single Axis Knee, Pylon, SACH Foot, Endoskeletal System	
L5321		Above Knee, Molded Socket, Open End, SACH Foot, Endoskeletal System, Single Axis Knee	
L5321***		Above Knee, Molded Socket, Open End, SACH Foot, Endoskeletal System, Single Axis Knee	
L5331		Knee Disarticulation, Canadian Type, Molded Socket, Endoskeletal System, Hip Joint, Single Axis Knee SACH Foot	X

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Procedure Code	Modifier	Procedure Code Description	RequiresPA
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	
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, Non-Alignable System, 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, Endoskeletal System, Above The Knee-Knee Disarticulation, 4 Bar Linkage, With Friction Swing Phase Control	
L5613		Addition To Lower Extremity, Endoskeletal System, Above Knee-Knee Disarticulation, 4 Bar Linkage, With Hydraulic Swing Phase Control	
L5618		Addition To Lower Extremity, Test Socket, Symes	
L5620		Addition To Lower Extremity, Test Socket, Below Knee	
L5620***		Addition To Lower Extremity, Test Socket, Below Knee	
L5622		Addition to lower extremity, test socket, knee disarticulation	

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Procedure Code	Modifier	Procedure Code Description	RequiresPA
L5624		Addition To Lower Extremity, Test Socket, Above Knee	
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	
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	
L5631***		Addition To Lower Extremity, Above Knee Or Knee Disarticulation, Acrylic Socket	
L5632		Addition To Lower Extremity, Symes Type, 'Ptb' Brim Design Socket	
L5634		Addition To Lower Extremity, Smyes 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	
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	
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***		Additions 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, Plastazote Or Equal)	
L5661		Addition To Lower Extremity, Socket Insert, Multi-Durometer Symes	
L5665		Addition To Lower Extremity,Socket Insert,Multi-Durometer,Below Knee	
L5666		Addition To Lower Extremity, Below Knee, Cuff Suspension	
L5668		Addition To Lower Extremity, Below Knee, Molded Distal Cushion	

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Procedure Code	Modifier	Procedure Code Description	RequiresPA
L5670		Addition To Lower Extremity, Below Knee, Molded Supracondylar Suspension ('Pts' Or Similar)	
L5671***		Addition To Lower Extremity, Below Knee / Above Knee Suspension Locking Mechanism (Shuttle, Lanyard Or Equal), Excludes Socket Insert	
L5672		Addition to lower extremity, below knee, removable medial brim suspension	
L5673***		Addition To Lower Extremity, Below Knee/Above Knee, Custom Fabricated From Existing Mold Or Prefabricated, Socket Insert, Silicone Gel, Elastomeric Or	
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	
L5679***		Addition To Lower Extremity, Below Knee/Above Knee, Custom Fabricated From Existing Mold Or Prefabricated, Socket Insert, Silicone Gel, Elastomeric Or	
L5680		Addition To Lower Extremity, Below Knee, Thigh Lacer, Nonmolded	
L5681		Addition To Lower Extremity, Below Knee/Above Knee, Custom Fabricated Socket Insert For Congenital Or Atypical Traumatic Amputee, Silicone Gel, Elastomeric	
L5682		Addition To Lower Extremity, Below Knee, Thigh Lacer, Gluteal/Ischial, Molded	
L5683		Addition To Lower Extremity, Below Knee/Above Knee, Custom Fabricated Socket Insert For Other Than Congenital Or Atypical Traumatic Amputee, Silicone Gel,	
L5684		Addition To Lower Extremity, Below Knee, Fork Strap	
L5685***		Addition To Lower Extremity Prosthesis, Below Knee, Suspension/Sealing Sleeve, With Or Without Valve, Any Material, Each	
L5685***		Addition To Lower Extremity Prosthesis, Below Knee, Suspension/Sealing Sleeve, With Or Without Valve, Any Material, Each	
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	
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	

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Procedure Code	Modifier	Procedure Code Description	RequiresPA
L5704***		Custom Shaped Protective Cover, Below Knee	
L5705***		Custom Shaped Protective Cover, Above Knee	
L5706		Custom Shaped Protective Cover, Knee Disarticulation	
L5710		Addition, exoskeletal knee-shin system, single axis, manual lock	
L5711		Additions 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	
L5781		Addition To Lower Limb Prosthesis, Vacuum Pump, Residual Limb Volume Management And Moisture Evacuation System	
L5782		Addition To Lower Limb Prosthesis, Vacuum Pump, Residual Limb Volume Management And Moisture Evacuation System, Heavy Duty	
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)	
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	

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Procedure Code	Modifier	Procedure Code Description	RequiresPA
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	
L5848		Addition To Endoskeletal, Knee-Shin System, Hydraulic Stance Extension, Dampening Feature, With Or Without Adjustability	
L5850***		Addition, Endoskeletal System, Above Knee Or Hip Disarticulation, Knee Extension Assist	
L5855		Addition, Endoskeletal System, Hip Disarticulation, Mechanical Hip Extension	
L5856**		Addition To Lower Extremity Prosthesis, Endoskeletal Knee-Shin System, Microprocessor Control Feature, Swing And Stance Phase, Includes Electronic	X
L5857		Addition To Lower Extremity Prosthesis, Endoskeletal Knee-Shin System, Microprocessor Control Feature, Swing Phase Only, Includes Electronic	
L5858**		Addition To Lower Extremity Prosthesis, Endoskeletal Knee Shin System, Microprocessor Control Feature, Stance Phase Only, Includes Electronic	X
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, alignable system	
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	
L5970		All Lower Extremity Prostheses, Foot, External Keel, SACH Foot	
L5971		All lower extremity prosthesis, solid ankle cushion heel (sach) foot, replacement only	
L5972		All Lower Extremity Prostheses, Flexible Keel Foot (Safe, STEN, Bock Dynamic Or Equal)	
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, Multiaxial Ankle/Foot	
L5979		All Lower Extremity Prosthesis, Multi-Axial Ankle, Dynamic Response Foot, One Piece System	

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Procedure Code	Modifier	Procedure Code Description	RequiresPA
L5980		All Lower Extremity Prostheses, Flex Foot System	
L5982		All exoskeletal lower extremity prostheses, axial rotation unit	
L5984		All Endoskeletal Lower Extremity Prosthesis, Axial Rotation Unit, With Or Without Adjustability	
L5985		All Endoskeletal Lower Extremity Prostheses, Dynamic Prosthetic Pylon	
L5986***		All Lower Extremity Prostheses, Multi-Axial Rotation Unit (MCP Or Equal)	
L5987		All Lower Extremity Prosthesis, Shank Foot System With Vertical Loading Pylon	
L5990		Addition To Lower Extremity Prosthesis, User Adjustable Heel Height	
L5995		Addition To Lower Extremity Prosthesis, Heavy Duty Feature (For Patient Weight > 300 Lbs)	
L5999		Lower extremity prosthesis, not otherwise specified	
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)	
L6025		Transcarpal/Metacarpal Or Partial Hand Disarticulation Prosthesis, External Power, Self-Suspended, Inner Socket With Removable Forearm Section, Electrodes	
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	

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Procedure Code	Modifier	Procedure Code Description	RequiresPA
		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	
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	
L6621		Upper Extremity Prosthesis Addition, Flexion/Extension Wrist With Or Without Friction, For Use With External Powered Terminal Device	
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	

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Procedure Code	Modifier	Procedure Code Description	RequiresPA
L6637		Upper extremity addition, nudge control elbow lock	
L6638		Upper Extremity Addition To Prosthesis, Electric Locking Feature, Only For Use With Manually Powered Elbow	
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	
L6647		Upper Extremity Addition, Shoulder Lock Mechanism, Body Powered Actuator	
L6648		Upper Extremity Addition, Shoulder Lock Mechanism, External Powered Actuator	
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, (E.G. Figure Of Eight Type), Dual Cable Design	
L6680		Upper Extremity Addition, Test Socket, Wrist Disarticulation Or Below Elbow	
L6682**		Upper Extremity Addition, Test Socket, Elbow Disarticulation Or Above Elbow	
L6882		Microprocessor control feature, addition to upper limb prosthetic terminal device	X
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 Elbow 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	
L6703		Terminal Device, Passive Hand/Mitt, Any Material, Any Size	
L6704		Terminal Device, Sport/Recreational/Work Attachment, Any Material, Any Size	
L6706		Terminal Device, Hook, Mechanical, Voluntary Opening, Any Material, Any Size, Lined Or Unlined	
L6707		Terminal Device, Hook, Mechanical, Voluntary Closing, Any Material, Any Size, Lined Or Unlined	
L6708		Terminal Device, Hand, Mechanical, Voluntary Opening, Any Material, Any Size	
L6709		Terminal Device, Hand, Mechanical, Voluntary Closing, Any Material, Any Size	

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Procedure Code	Modifier	Procedure Code Description	RequiresPA
L6882**		Microprocessor Control Feature, Addition To Upper Limb Prosthetic Terminal Device	X
L6890**		Addition To Upper Extremity Prosthesis, Glove For Terminal Device, Any Material, Prefabricated, Includes Fitting And Adjustment	
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	X
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,	
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	
L7007		Electric Hand, Switch Or Myoelectric Controlled, Adult	
L7008		Electric Hand, Switch Or Myoelectric, Controlled, Pediatric	
L7009		Electric Hook, Switch Or Myoelectric Controlled, Adult	

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Procedure Code	Modifier	Procedure Code Description	RequiresPA
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	
L7360		Six Volt Battery, Otto Bock Or Equal, Each	
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	
L7367		Lithium Ion Battery, Replacement	
L7368		Lithium Ion Battery Charger	
L7400		Addition To Upper Extremity Prothesis, Below Elbow/Wrist Disarticulation, Ultralight Material (Titanium, Carbon Fiber Or Equal	
L7403		Addition To Upper Extremity Prothesis, Below Elbow/Wrist Disarticulation, Acrylic Material	
L7499		Upper extremity prosthesis, not otherwise specified	
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	
L7520		Repair Prosthetic Device, Labor Component, Per 15 Minutes	
L7902		Tension Ring, For Vacuum Eerection Device, Any Type, Replacement Only, Each	
L8000		Breast Prosthesis, Mastectomy Bra	
L8015		External Breast Prosthesis Garment, With Mastectomy Form, Post Mastectomy	
L8020		Breast Prosthesis, Mastectomy Form	
L8030		Breast Prosthesis, Silicone Or Equal	
L8035		Custom Breast Prosthesis, Post Mastectomy, Molded To Patient Model	
L8039		Breast Prosthesis, Not Otherwise 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	
L8400***		Prosthetic Sheath, Below Knee, Each	
L8410*		Prosthetic Sheath, Above Knee, Each	
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	

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Procedure Code	Modifier	Procedure Code Description	RequiresPA
L8420***		Prosthetic Sock, Multiple Ply, Below Knee, Each	
L8430***		Prosthetic Sock, Multiple Ply, Above Knee, Each	
L8435		Prosthetic Sock, Multiple Ply, Upper Limb, Each	
L8440***		Prosthetic Shrinker, Below Knee, Each	
L8460***		Prosthetic Shrinker, Above Knee, Each	
L8465		Prosthetic Shrinker, Upper Limb, Each	
L8470***		Prosthetic Sock, Single Ply, Fitting, Below Knee, Each	
L8480***		Prosthetic Sock, Single Ply, Fitting, Above Knee, Each	
L8485		Prosthetic Sock, Single Ply, Fitting, Upper Limb, Each	
L8501		Tracheostomy Speaking Valve	
S1040		Cranial Remolding Orthosis, Pediatric, Rigid, With Soft Interface Material, Custom Fabricated, Includes Fitting And Adjustment(S)	X
S5498		Home Infusion Therapy (HIT),Catheter Care/Maintenance, Single (Single Lumen), Includes Administrative Services, Professional Pharmacy Services, Care Coordination, And All Necessary Supplies And Equipment (Drugs And Nursing Visits Coded Separately)	
S5501		HIT, Catheter Care/Maintenance, Complex (More Than One Lumen), Includes Administrative Services, Professional Pharmacy Services, Care Coordination, And All Necessary Supplies And Equipment (Drugs And Nursing Visits Coded Separately)	
S5520		HIT, All Supplies (Including Catheter) Necessary For Peripherally Inserted Central Venous Catheter (PICC) Line Insertion	
S5521		HIT, All Supplies (Including Catheter) Necessary For Midline Catheter Insertion	
S8189		Tracheostomy Supply , Not Otherwise Classified (Ex. Custom Specialty Trach)	X
S8270		Enuresis Alarm	
S8999		Resuscitation Bag (For Use By Patients On Artificial Respiration During Power Failure Or Other Catastrophic Event)	
S9326		HIT, Continuous (24 Hours Or More) Pain Management Infusion, Includes Administrative Services, Professional Pharmacy Services, Care Coordination, And All Necessary Supplies And Equipment (Drugs And Nursing Visits Coded Separately)	
S9330		HIT, Continuous (24 Hours Or More) Chemotherapy Infusion, Includes Administrative Services, Professional Pharmacy Services, Care Coordination, And All Necessary Supplies And Equipment (Drugs And Nursing Visits Coded Separately)	
S9336		HIT, Continuous Anticoagulant Infusion,(E.G. , Heparin) Includes Administration Services, Professional Pharmacy Services, Care Coordination, And All Necessary Supplies And Equipment (Drugs And Nursing Visits Coded Separately)	
S9347		HIT, Uninterrupted, Long Term, Controlled Rate Intravenous Or Subcutaneous Infusion Therapy (E.G. Epoprostenol), Includes Administrative Services, Professional Pharmacy Services, Care Coordination, And All Necessary Supplies And Equipment (Drugs And Nursing Visits Coded Separately)	
S9351		HIT, Continuous Or Intermittent Anti-Emetic Infusion Therapy; Includes Administrative Services, Professional Pharmacy Services, Care Coordination, And All Necessary Supplies And Equipment (Drugs And Nursing Visits Coded Separately)	
S9373		HIT, Hydration; Once Every 6 Hours; Includes Administrative Services, Professional Pharmacy Services, Care Coordination, And All Necessary Supplies And Equipment (Drugs And Nursing Visits Coded Separately)	

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Procedure Code	Modifier	Procedure Code Description	RequiresPA
S9379		HIT, Infusion Therapy; Not Otherwise Classified; Includes Administrative Services, Professional Pharmacy Services, Care Coordination, And All Necessary Supplies And Equipment (Drugs And Nursing Visits Coded Separately) Anticipating That New Infusion Therapies Will Be Developed Or That A Current Therapy Has Been Overlooked, The Ltc Medical And Quality Review Unit Will Consider Authorization Of Other Therapies On An Individual Basis. These Special Requests Will Require Peer Reviewed Medical Literature Documentation And Review By Medicaid's Medical Director	X
S9490		HIT, Corticosteroid Infusion; Includes Administrative Services, Professional Pharmacy Services, Care Coordination, And All Necessary Supplies And Equipment (Drugs And Nursing Visits Coded Separately)	
S9500		HIT, Antibiotic, Antviral, Or Antifungal; Once Every 24 Hours; Includes Administrative Services, Professional Pharmacy Services, Care Coordination, And All Necessary Supplies And Equipment (Drugs And Nursing Visits Coded Separately)	
S9501		HIT, Antibiotic, Antviral, Or Antifungal; Once Every 12 Hours; Includes Administrative Services, Professional Pharmacy Services, Care Coordination, And All Necessary Supplies And Equipment (Drugs And Nursing Visits Coded Separately)	
S9502		HIT, Antibiotic, Antviral, Or Antifungal; Once Every 8 Hours; Includes Administrative Services, Professional Pharmacy Services, Care Coordination, And All Necessary Supplies And Equipment (Drugs And Nursing Visits Coded Separately)	
S9503		HIT, Antibiotic, Antviral, Or Antifungal; Once Every 6 Hours; Includes Administrative Services, Professional Pharmacy Services, Care Coordination, And All Necessary Supplies And Equipment (Drugs And Nursing Visits Coded Separately)	
S9504		HIT, Antibiotic, Antviral, Or Antifungal Therapy; Once Every 4 Hours; Includes Administrative Services, Professional Pharmacy Services, Care Coordination, And All Necessary Supplies And Equipment (Drugs And Nursing Visits Coded Separately)	
T4521		Adult Sized Disposable Incontinence Product, Brief/ Diaper Small, Each	X
T4522		Adult Sized Disposable Incontinence Product, Brief/Diaper Medium, Each	X
T4523		Adult Sized Disposable Incontinence Product, Brief/Diaper Large, Each	X
T4524		Adult Sized Disposable Incontinence Product, Brief/Diaper Extra Large, Each	X
T4529		Pediatric Sized Disposable Incontinence Product ,Brief/Diaper Small/Medium Size, Each	X
T4530		Pediatric Sized Disposable Incontinence Product, Brief/Diaper, Large Size, Each	X
V5336		Repair/Modification Of Augmentative Communicative System Or Device (Excludes Adaptive Hearing Aid)	X

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Q Tobacco Cessation

Q.1 Tobacco Cessation Counseling Service for Pregnant Women

Beginning January 1, 2014, the Alabama Medicaid Agency will cover a new smoking cessation benefit for Medicaid-eligible pregnant women for the following provider types: **Outpatient hospitals, physicians, nurse practitioners, nurse midwives, county health departments, federally qualified health care centers (FQHCs), rural health clinics (RHCs), opticians, optometrists, pharmacies, mental health centers.**

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.

NOTE:

Medical record documentation must support each individual, face-to-face counseling session. Documentation must show, for each Medicaid beneficiary for whom a smoking and tobacco-use cessation counseling or counseling to prevent tobacco use claim is made, standard information, along with sufficient beneficiary history to adequately demonstrate that Medicaid coverage conditions were met.

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Q.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.

Q.2.1 Benefits

Medicaid will reimburse up to four face- to-face counseling sessions in a 12-month period.

Q.2.2 Limitations

The reimbursement period will begin in the prenatal period and continue through the postpartum period (12 months after delivery or pregnancy end).

Eligibility should be verified **prior to rendering** services to **ANY** Medicaid recipient.

Counseling in the tobacco cessation setting is interactive and includes education. To enhance the effectiveness and efficiency of Medicaid processing, your counseling/education topics must be based on patient need and on protocol requirements outlined in the Public Health Services Guidelines: https://www.ahrq.gov/topics/tobacco-use.html

Q.3 Cost Sharing (Copay)

Copayment does not apply to services provided to pregnant women.

Q.4 Completing the Claims Form

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

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.

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NOTE:

When filing a claim on paper, a CMS-1500 claim form is required. **Pharmacies must bill for these specific services through their DME NPI.**

Q.4.1 Time Limit for Filing Claims

Medicaid requires all claims from 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.

Q.4.2 Diagnosis Codes

Providers are to bill all claims to Gainwell 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 - 10th Revision - Clinical Modification (ICD-10-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, AMA Plaza 330 North Wabash Ave, Suite 39300 Chicago, IL 60611-5885, or 1-800-621-8335.

The following diagnosis codes must be billed on the claim (UB-04 or CMS-1500 claim form) in order to be reimbursed by Medicaid:

ICD 9 Diagnosis	Description	ICD 10 Diagnosis	Description
V220-V222	Supervision of Normal Pregnancy	Z331 Z333	Pregnant State, Incidental Pregnancy State Gestational Carrier
V230-V233	Supervision of high-risk pregnancy	O0900-O0993	Supervision of high-risk pregnancy/ Pregnancy with other poor obstetric history
		O3680X0-O3680X9	Pregnancy wit Inconclusive Fetal Viability, Other Fetus (see ICD-10 for details of diagnosis description)
		Z3400-Z3493	Encounter for Supervision of Normal Pregnancy (see ICD-10 for details of diagnosis description)

OR

ICD 9 Diagnosis	Description	ICD 10 Diagnosis	Description
V242	Routine postpartum follow-up	Z392	Encounter for routine postpartum follow-up

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AND

ICD 9 Diagnosis	Description	ICD 10 Diagnosis	Description
3051	Tobacco use disorder	F17200-F17299	Nicotine Dependence, unspecified (see ICD-10 for details of diagnosis description)

NOTE:

ICD-9 codes should be used for claims submitted with dates of service prior to or equal to 09/30/2015.

ICD-10 codes should be used for claims submitted with dates of service on/after 10/01/2015.

NOTE:

ICD-9 or ICD-10 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.

Q.4.3 Place of Service Codes

The following place of service codes applies when filing claims for face to face tobacco cessation counseling sessions:

Place of Service Code	Description
01	Pharmacy
11	Office
12	Home
22	Outpatient Hospital
23	Emergency Room (Hospital)
24	Ambulatory Surgical Centers
25	Birthing Center
51	Inpatient Psychiatric Facility
53	Community Rehabilitative Services Center
54	Intermediate Care/ Facility./Mentally Retarded
55	Residential Substance Abuse Treatment Center
56	Psychiatric Residential Treatment Center
65	End Stage Renal Disease Treatment Facility
71	State or Local Public Health Clinic
72	Rural Health Clinic

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Q.4.4 Procedure Codes and Modifiers

Medicaid uses the Healthcare Common Procedure Coding System (HCPCS). HCPCS is composed of the following:

- American Medical Association's Current Procedural Terminology (CPT)
- Nationally assigned codes developed by Medicare

The (837) Professional and Institutional electronic claims and the paper claim have been modified to accept up to four Procedure Code Modifiers.

Claims for **face to face tobacco cessation counseling sessions** are limited to the following **two** procedure codes and modifiers. The following procedure codes are covered services when provided by any health care professional who is legally authorized to furnish such services under State law within their scope of practice and who is authorized to provide Medicaid covered services other than tobacco cessation services, and by or under the supervision of a physician.

Code	Modifier	Description
99406		Smoking and tobacco use cessation counseling visit; intermediate, greater than three minutes up to 10 minutes
99407		Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes

NOTE:

Additional information regarding this mandate can be accessed at http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD11-007.pdf

Q.4.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to the following circumstances:

- Claims With Third Party Denials

NOTE:

When an attachment is required, a hard copy CMS-1500 claim form must be submitted**.**

Refer to Section 5.7, Required Attachments, for more information on attachments

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Q.5 Pharmacy Program

Pharmacy Coverage of Smoking Cessation Products for Plan First Recipients

Effective for dates of service October 1, 2012, selected smoking cessation products are covered for Medicaid recipients on the Plan First program. Prior authorization will not be required for Plan First recipients.

Pharmacy Coverage of Smoking Cessation Products for Medicaid Eligible Recipients

Effective January 1, 2014, smoking cessation products will be covered for Medicaid eligible recipients. Prior authorization through the Pharmacy Administrative Services contractor will be required (outside of the Plan First Program). In order for requests to be approved, prescribers must include a copy of the Department of Public Health's Alabama Tobacco Quitline Patient Referral/Consent Form signed by the recipient with the prior authorization request. Approval will be granted for up to three months at a time (unless duration of therapy differs). Only one course of therapy will be approved per calendar year.

Q.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
CMS-1500 Claim Filing Instructions	Section 5.2
Medical Medicaid/Medicare-related Claim Filing Instructions	Section 5.6.1
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N

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R Ambulance (Ground and Air) Diagnosis Codes

Diagnosis codes for **emergency ground transportation** are listed below. If you bill a diagnosis code for an **emergency ground transport** that is not on this list, your claim will deny. For non-emergency ground transport, any valid ICD-9 or ICD-10 diagnosis code may be used based upon the dates of service noted below.

NOTE:

ICD-9 codes should be used for claims submitted with dates of service prior to or equal to 09/30/2015.

ICD-10 codes should be used for claims submitted with dates of service on or after 10/01/2015.

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Diagnosis Code From	Diagnosis Code To	ICD Indicator
0221	0221	9
0339	0339	9
04082	04082	9
0785	0785	9
1173	1173	9
25010	25033	9
25080	25081	9
2510	2510	9
28262	28262	9
2900	2900	9
29010	29011	9
29013	29013	9
29021	29021	9
2903	2903	9
29041	29043	9
2908	2908	9
2909	2909	9
2910	2910	9
2913	29281	9
2930	2931	9
29420	29420	9
29500	29580	9
29600	29656	9
29660	29666	9
2980	2989	9
30016	30016	9
311	311	9
3229	3229	9
34500	3452	9
34540	34551	9
34570	34581	9
3485	3485	9
41000	41189	9
4131	4131	9
4139	4139	9
41400	41401	9
41412	41412	9
4148	42731	9
42741	42843	9
4289	4289	9
4292	4292	9
4294	4296	9
42981	42982	9
42989	42989	9
430	436	9
4371	4378	9
44321	44329	9
44401	4449	9
44501	44589	9
449	449	9
45379	45379	9
4539	4539	9
4658	4659	9
4800	4878	9
5060	5069	9
5109	5122	9
5171	5171	9
5180	5181	9
5184	5184	9
51851	51851	9
51853	51853	9
51881	51889	9
51901	51911	9
5192	5193	9
53783	53784	9
5400	5401	9
56969	56969	9
56985	56986	9
5722	5722	9
5728	5728	9
5780	5789	9
5921	5929	9
6089	6089	9
6259	6259	9
63300	63301	9
63410	63570	9
63572	63572	9
63610	63670	9
6381	6387	9
6391	64083	9
64100	64193	9
64220	64221	9
64223	64223	9
64244	64274	9
64400	64421	9
65270	65273	9
65281	65933	9
66130	66133	9
66300	66323	9
66600	66600	9
66602	66604	9
6822	6822	9
74100	74103	9
7420	7420	9
7423	7423	9
7429	7429	9
7450	7479	9
7503	7503	9
7566	7566	9
7597	7597	9
7621	7625	9
76500	76520	9
7670	7670	9
7674	7674	9
7678	7678	9
7682	7686	9
7689	769	9
77010	77018	9
7707	7707	9
77081	77085	9
77088	77089	9
77181	77181	9
7720	7720	9
77210	77214	9

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Diagnosis Code From	Diagnosis Code To	ICD Indicator
7723	7724	9
7728	7729	9
7733	7733	9
7753	7753	9
7755	7756	9
77581	77581	9
7760	7760	9
7762	7762	9
7776	7779	9
7784	7785	9
7790	7792	9
7794	7795	9
77981	77982	9
77985	77985	9
78001	78039	9
78550	78559	9
78600	78603	9
7861	7861	9
78650	78659	9
78900	78909	9
78940	78951	9
78960	78969	9
7901	7903	9
79901	7991	9
79989	8057	9
80600	8089	9
8091	8091	9
81010	81100	9
81102	81119	9
81210	81219	9
81230	81231	9
81250	81259	9
81310	81318	9
81330	81333	9
81350	81354	9
81390	81393	9
8181	8181	9
8191	8191	9
82000	8221	9
82310	82312	9
82330	82332	9
82390	82391	9
8241	8241	9
8243	8243	9
8245	8245	9
8247	8247	9
8249	8249	9
8271	8271	9
8281	8281	9
8500	8631	9
86340	86359	9
86381	86400	9
86410	86410	9
86500	8691	9
8703	870	9
8704	8704	9
8710	8716	9
8731	8731	9
8738	8745	9
8750	8761	9
8771	8787	9
8791	8797	9
8799	8822	9
8840	8841	9
8870	8912	9
8941	8941	9
8960	8977	9
9251	9268	9
92700	92711	9
9278	9278	9
92800	92821	9
9331	9348	9
9402	9409	9
94120	94159	9
94230	94259	9
94320	94359	9
94430	94458	9
94530	94559	9
9463	9465	9
9471	9478	9
94810	9490	9
9500	9529	9
9580	9581	9
9584	9584	9
9586	9586	9
9598	9599	9
9916	9916	9
9920	9927	9
9940	9941	9
9947	9948	9
9950	9950	9
99592	99592	9
99671	99674	9
99702	99702	9
9971	9972	9
99779	99779	9
99799	99799	9
99800	99832	9
9991	9991	9
9999	9999	9
E911	E9139	9
E915	E915	9
E9288	E9289	9
E9530	E9538	9
E963	E963	9
E9830	E9838	9
V419	V419	9
A1884	A1884	0
A021	A021	0
A221	A221	0
A3701	A3701	0
A3711	A3711	0
A3781	A3781	0
A3791	A3791	0
A481	A481	0
A483	A483	0
B250	B250	0

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Diagnosis Code From	Diagnosis Code To	ICD Indicator
B440	B440	0
B7781	B7781	0
D5700	D5702	0
D62	D62	0
D7801	D7822	0
E035	E035	0
E1010	E1011	0
E10641	E10641	0
E1065	E1069	0
E1100	E1101	0
E11641	E11641	0
E1165	E1169	0
E1300	E1311	0
E13641	E13641	0
E15	E15	0
E3601	E3612	0
F0151	F0151	0
F0390	F0390	0
F05	F05	0
F10121	F10121	0
F10150	F10151	0
F10221	F10221	0
F10231	F10231	0
F10250	F10251	0
F10920	F10929	0
F10950	F10951	0
F11121	F11121	0
F11150	F11151	0
F11220	F11221	0
F11229	F1123	0
F11250	F11251	0
F11920	F11921	0
F11929	F1193	0
F11950	F11951	0
F12120	F12121	0
F12129	F12151	0
F12220	F12221	0
F12229	F12251	0
F12920	F12921	0
F12929	F12951	0
F13121	F13129	0
F13150	F13151	0
F13220	F13239	0
F13250	F13251	0
F13920	F13939	0
F13950	F13951	0
F14121	F14121	0
F14129	F14129	0
F14150	F14151	0
F14220	F14221	0
F14229	F1423	0
F14250	F14251	0
F14920	F14921	0
F14929	F14929	0
F14950	F14951	0
F15121	F15121	0
F15129	F15129	0
F15150	F15151	0
F15220	F15221	0
F15229	F1523	0
F15250	F15251	0
F15920	F15921	0
F15929	F1593	0
F15950	F15951	0
F16121	F16121	0
F16129	F16129	0
F16150	F16151	0
F16220	F16229	0
F16250	F16251	0
F16920	F16929	0
F16950	F16951	0
F17203	F17203	0
F17213	F17213	0
F17223	F17223	0
F17293	F17293	0
F18120	F18129	0
F18150	F18151	0
F18220	F18229	0
F18250	F18251	0
F18920	F18929	0
F18950	F18951	0
F19121	F19121	0
F19129	F19129	0
F19150	F19151	0
F19220	F19221	0
F19229	F19239	0
F19250	F19251	0
F19920	F19921	0
F19929	F19939	0
F19950	F19951	0
F200	F202	0
F205	F2089	0
F23	F23	0
F250	F28	0
F3010	F304	0
F309	F3164	0
F3173	F3178	0
F3189	F3189	0
F320	F325	0
F329	F3342	0
F339	F339	0
F4489	F4489	0
G039	G039	0
G40001	G40319	0
G450	G452	0
G454	G462	0
G9731	G9732	0
G9748	G9752	0
H59111	H59329	0
H9521	H9542	0
I200	I229	0
I234	I235	0
I240	I25119	0
I2542	I25799	0

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Diagnosis Code From	Diagnosis Code To	ICD Indicator
I2589	I509	0
I511	I512	0
I5189	I5189	0
I6000	I671	0
I674	I6782	0
I67841	I6789	0
I682	I682	0
I7401	I76	0
I7771	I7779	0
I8291	I8291	0
I970	I97191	0
I97410	I97791	0
I9788	I9789	0
J069	J069	0
J1000	J123	0
J1289	J181	0
J188	J189	0
J680	J689	0
J80	J810	0
J869	J930	0
J940	J949	0
J9501	J9509	0
J9561	J95812	0
J95830	J95831	0
J9600	J9801	0
J9811	J982	0
J984	J985	0
K2971	K2971	0
K31811	K31811	0
K3182	K3182	0
K352	K353	0
K5521	K5521	0
K6381	K6381	0
K7041	K7041	0
K7111	K7111	0
K7201	K7201	0
K7211	K7291	0
K9161	K9172	0
K91840	K91841	0
K920	K922	0
K9401	K9401	0
K9409	K9409	0
K9411	K9411	0
K9419	K9419	0
L02211	L02219	0
L03311	L03316	0
L03319	L03326	0
L03329	L03329	0
L7601	L7622	0
M3211	M3212	0
M4840XA	M4840XA	0
M4841XA	M4841XA	0
M4842XA	M4842XA	0
M4843XA	M4843XA	0
M4844XA	M4844XA	0
M4845XA	M4845XA	0
M4846XA	M4846XA	0
M4847XA	M4847XA	0
M4848XA	M4848XA	0
M4850XA	M4850XA	0
M4851XA	M4851XA	0
M4852XA	M4852XA	0
M4853XA	M4853XA	0
M4854XA	M4854XA	0
M4855XA	M4855XA	0
M4856XA	M4856XA	0
M4857XA	M4857XA	0
M4858XA	M4858XA	0
M8000XA	M8000XA	0
M80011A	M80011A	0
M80012A	M80012A	0
M80019A	M80019A	0
M80021A	M80021A	0
M80022A	M80022A	0
M80029A	M80029A	0
M80031A	M80031A	0
M80032A	M80032A	0
M80039A	M80039A	0
M80041A	M80041A	0
M80042A	M80042A	0
M80049A	M80049A	0
M80051A	M80051A	0
M80052A	M80052A	0
M80059A	M80059A	0
M80061A	M80061A	0
M80062A	M80062A	0
M80069A	M80069A	0
M80071A	M80071A	0
M80072A	M80072A	0
M80079A	M80079A	0
M8008XA	M8008XA	0
M8080XA	M8080XA	0
M80811A	M80811A	0
M80812A	M80812A	0
M80819A	M80819A	0
M80821A	M80821A	0
M80822A	M80822A	0
M80829A	M80829A	0
M80831A	M80831A	0
M80832A	M80832A	0
M80839A	M80839A	0
M80841A	M80841A	0
M80842A	M80842A	0
M80849A	M80849A	0
M80851A	M80851A	0
M80852A	M80852A	0
M80859A	M80859A	0
M80861A	M80861A	0
M80862A	M80862A	0
M80869A	M80869A	0
M80871A	M80871A	0
M80872A	M80872A	0
M80879A	M80879A	0
M8088XA	M8088XA	0
M810	M810	0
M818	M818	0
M8430XA	M8430XA	0

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Diagnosis Code From	Diagnosis Code To	ICD Indicator
M84311A	M84311A	0
M84312A	M84312A	0
M84319A	M84319A	0
M84321A	M84321A	0
M84322A	M84322A	0
M84329A	M84329A	0
M84331A	M84331A	0
M84332A	M84332A	0
M84333A	M84333A	0
M84334A	M84334A	0
M84339A	M84339A	0
M84341A	M84341A	0
M84342A	M84342A	0
M84343A	M84343A	0
M84344A	M84344A	0
M84345A	M84345A	0
M84346A	M84346A	0
M84350A	M84350A	0
M84351A	M84351A	0
M84352A	M84352A	0
M84353A	M84353A	0
M84359A	M84359A	0
M84361A	M84361A	0
M84362A	M84362A	0
M84363A	M84363A	0
M84364A	M84364A	0
M84369A	M84369A	0
M84371A	M84371A	0
M84372A	M84372A	0
M84373A	M84373A	0
M84374A	M84374A	0
M84375A	M84375A	0
M84376A	M84376A	0
M84377A	M84377A	0
M84378A	M84378A	0
M84379A	M84379A	0
M8438XA	M8438XA	0
M8440XA	M8440XA	0

Diagnosis Code From	Diagnosis Code To	ICD Indicator
M84411A	M84411A	0
M84412A	M84412A	0
M84419A	M84419A	0
M84421A	M84421A	0
M84422A	M84422A	0
M84429A	M84429A	0
M84431A	M84431A	0
M84432A	M84432A	0
M84433A	M84433A	0
M84434A	M84434A	0
M84439A	M84439A	0
M84441A	M84441A	0
M84442A	M84442A	0
M84443A	M84443A	0
M84444A	M84444A	0
M84445A	M84445A	0
M84446A	M84446A	0
M84451A	M84451A	0
M84452A	M84452A	0
M84453A	M84453A	0
M84454A	M84454A	0
M84459A	M84459A	0
M84461A	M84461A	0
M84462A	M84462A	0
M84463A	M84463A	0
M84464A	M84464A	0
M84469A	M84469A	0
M84471A	M84471A	0
M84472A	M84472A	0
M84473A	M84473A	0
M84474A	M84474A	0
M84475A	M84475A	0
M84476A	M84476A	0
M84477A	M84477A	0
M84478A	M84478A	0
M84479A	M84479A	0
M8448XA	M8448XA	0
M8450XA	M8450XA	0

Diagnosis Code From	Diagnosis Code To	ICD Indicator
M84511A	M84511A	0
M84512A	M84512A	0
M84519A	M84519A	0
M84521A	M84521A	0
M84522A	M84522A	0
M84529A	M84529A	0
M84531A	M84531A	0
M84532A	M84532A	0
M84533A	M84533A	0
M84534A	M84534A	0
M84539A	M84539A	0
M84541A	M84541A	0
M84542A	M84542A	0
M84549A	M84549A	0
M84550A	M84550A	0
M84551A	M84551A	0
M84552A	M84552A	0
M84553A	M84553A	0
M84559A	M84559A	0
M84561A	M84561A	0
M84562A	M84562A	0
M84563A	M84563A	0
M84564A	M84564A	0
M84569A	M84569A	0
M84571A	M84571A	0
M84572A	M84572A	0
M84573A	M84573A	0
M84574A	M84574A	0
M84575A	M84575A	0
M84576A	M84576A	0
M8458XA	M8458XA	0
M8460XA	M8460XA	0
M84611A	M84611A	0
M84612A	M84612A	0
M84619A	M84619A	0
M84621A	M84621A	0
M84622A	M84622A	0
M84629A	M84629A	0

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Diagnosis Code From	Diagnosis Code To	ICD Indicator
M84631A	M84631A	0
M84632A	M84632A	0
M84633A	M84633A	0
M84634A	M84634A	0
M84639A	M84639A	0
M84641A	M84641A	0
M84642A	M84642A	0
M84649A	M84649A	0
M84650A	M84650A	0
M84651A	M84651A	0
M84652A	M84652A	0
M84653A	M84653A	0
M84659A	M84659A	0
M84661A	M84661A	0
M84662A	M84662A	0
M84663A	M84663A	0
M84664A	M84664A	0
M84669A	M84669A	0
M84671A	M84671A	0
M84672A	M84672A	0
M84673A	M84673A	0
M84674A	M84674A	0
M84675A	M84675A	0
M84676A	M84676A	0
M8468XA	M8468XA	0
M96621	M96831	0
N201	N201	0
N209	N209	0
N22	N22	0
N9961	N9972	0
N99820	N99821	0
O000	O000	0
O031	O0336	0
O0338	O034	0
O036	O0386	0
O0388	O047	0
O0481	O0489	0
O071	O072	0
O0731	O0736	0

Diagnosis Code From	Diagnosis Code To	ICD Indicator
O0738	O0739	0
O081	O0881	0
O0883	O089	0
O111	O119	0
O1410	O1423	0
O1500	O159	0
O200	O208	0
O328XX0	O328XX0	0
O4400	O479	0
O6000	O6023X9	0
O623	O623	0
O670	O679	0
O690XX0	O692XX9	0
O720	O720	0
O753	O753	0
P021	P025	0
P0700	P0718	0
P0730	P0730	0
P100	P102	0
P104	P112	0
P115	P119	0
P130	P130	0
P134	P134	0
P150	P158	0
P190	P220	0
P228	P229	0
P2400	P2430	0
P2480	P249	0
P270	P279	0
P282	P285	0
P2889	P2889	0
P2911	P2912	0
P293	P293	0
P2930	P2930	0
P2981	P2981	0
P360	P369	0
P500	P524	0
P526	P543	0
P546	P549	0

Diagnosis Code From	Diagnosis Code To	ICD Indicator
P560	P5699	0
P60	P60	0
P703	P704	0
P721	P721	0
P741	P744	0
P760	P760	0
P768	P769	0
P780	P781	0
P783	P789	0
P810	P819	0
P8330	P8339	0
P84	P911	0
P913	P915	0
P918	P919	0
P930	P938	0
P961	P962	0
Q010	Q019	0
Q030	Q039	0
Q049	Q054	0
Q059	Q059	0
Q069	Q069	0
Q0701	Q0703	0
Q079	Q079	0
Q200	Q289	0
Q390	Q394	0
Q790	Q791	0
Q897	Q897	0
R001	R001	0
R0601	R0601	0
R061	R061	0
R064	R064	0
R0681	R0681	0
R069	R069	0
R071	R092	0
R100	R10829	0
R1084	R109	0
R180	R180	0
R1930	R1937	0
R400	R402124	0

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Diagnosis Code From	Diagnosis Code To	ICD Indicator
R402210	R402224	0
R402310	R402324	0
R402340	R402344	0
R403	R404	0
R4182	R4182	0
R440	R440	0
R442	R449	0
R460	R4689	0
R55	R579	0
R6521	R6521	0
R6819	R6819	0
R69	R700	0
R7301	R739	0
R780	R780	0
S0102XA	S0102XA	0
S0104XA	S0104XA	0
S0190XA	S0190XA	0
S020XXA	S020XXB	0
S0210XA	S0210XB	0
S02110A	S02110B	0
S02111A	S02111B	0
S02112A	S02112B	0
S02113A	S02113B	0
S02118A	S02118B	0
S02119A	S02119B	0
S0219XA	S0219XB	0
S022XXA	S022XXB	0
S023XXA	S023XXB	0
S02400A	S02400B	0
S02401A	S02401B	0
S02402A	S02402B	0
S02411A	S02411B	0
S02412A	S02412B	0
S02413A	S02413B	0
S0242XA	S0242XB	0
S025XXA	S025XXB	0
S02600A	S02600B	0
S02609A	S02609B	0
S0261XA	S0261XB	0
S0262XA	S0262XB	0
S0263XA	S0263XB	0
S0264XA	S0264XB	0
S0265XA	S0265XB	0
S0266XA	S0266XB	0
S0267XA	S0267XB	0
S0269XA	S0269XB	0
S028XXA	S028XXB	0
S0291XA	S0291XB	0
S0292XA	S0292XB	0
S04011A	S04011A	0
S04012A	S04012A	0
S04019A	S04019A	0
S0402XA	S0402XA	0
S04031A	S04031A	0
S04032A	S04032A	0
S04039A	S04039A	0
S04041A	S04041A	0
S04042A	S04042A	0
S04049A	S04049A	0
S0410XA	S0410XA	0
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S0412XA	S0412XA	0
S0420XA	S0420XA	0
S0421XA	S0421XA	0
S0422XA	S0422XA	0
S0430XA	S0430XA	0
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S0432XA	S0432XA	0
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S0441XA	S0441XA	0
S0442XA	S0442XA	0
S0450XA	S0450XA	0
S0451XA	S0451XA	0
S0452XA	S0452XA	0
S0460XA	S0460XA	0
S0461XA	S0461XA	0
S0462XA	S0462XA	0
S0470XA	S0470XA	0
S0471XA	S0471XA	0
S0472XA	S0472XA	0
S04811A	S04811A	0
S04812A	S04812A	0
S04819A	S04819A	0
S04891A	S04891A	0
S04892A	S04892A	0
S04899A	S04899A	0
S049XXA	S049XXA	0
S0520XA	S0520XA	0
S0521XA	S0521XA	0
S0522XA	S0522XA	0
S0530XA	S0530XA	0
S0531XA	S0531XA	0
S0532XA	S0532XA	0
S0540XA	S0540XA	0
S0541XA	S0541XA	0
S0542XA	S0542XA	0
S0550XA	S0550XA	0
S0551XA	S0551XA	0
S0552XA	S0552XA	0
S0570XA	S0570XA	0
S0571XA	S0571XA	0
S0572XA	S0572XA	0
S060X0A	S060X0A	0
S060X1A	S060X1A	0
S060X2A	S060X2A	0
S060X3A	S060X3A	0
S060X4A	S060X4A	0
S060X5A	S060X5A	0
S060X6A	S060X6A	0
S060X7A	S060X7A	0
S060X8A	S060X8A	0
S060X9A	S060X9A	0
S061X0A	S061X0A	0
S061X1A	S061X1A	0

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Diagnosis Code From	Diagnosis Code To	ICD Indicator
S061X2A	S061X2A	0
S061X3A	S061X3A	0
S061X4A	S061X4A	0
S061X5A	S061X5A	0
S061X6A	S061X6A	0
S061X7A	S061X7A	0
S061X8A	S061X8A	0
S061X9A	S061X9A	0
S062X0A	S062X0A	0
S062X1A	S062X1A	0
S062X2A	S062X2A	0
S062X3A	S062X3A	0
S062X4A	S062X4A	0
S062X5A	S062X5A	0
S062X6A	S062X6A	0
S062X7A	S062X7A	0
S062X8A	S062X8A	0
S062X9A	S062X9A	0
S06300A	S06300A	0
S06301A	S06301A	0
S06302A	S06302A	0
S06303A	S06303A	0
S06304A	S06304A	0
S06305A	S06305A	0
S06306A	S06306A	0
S06307A	S06307A	0
S06308A	S06308A	0
S06309A	S06309A	0
S06310A	S06310A	0
S06311A	S06311A	0
S06312A	S06312A	0
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S06314A	S06314A	0
S06315A	S06315A	0
S06316A	S06316A	0
S06317A	S06317A	0
S06318A	S06318A	0
S06319A	S06319A	0
S06320A	S06320A	0

Diagnosis Code From	Diagnosis Code To	ICD Indicator
S06321A	S06321A	0
S06322A	S06322A	0
S06323A	S06323A	0
S06324A	S06324A	0
S06325A	S06325A	0
S06326A	S06326A	0
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S06330A	S06330A	0
S06331A	S06331A	0
S06332A	S06332A	0
S06333A	S06333A	0
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S06336A	S06336A	0
S06337A	S06337A	0
S06338A	S06338A	0
S06339A	S06339A	0
S06340A	S06340A	0
S06341A	S06341A	0
S06342A	S06342A	0
S06343A	S06343A	0
S06344A	S06344A	0
S06345A	S06345A	0
S06346A	S06346A	0
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S06348A	S06348A	0
S06349A	S06349A	0
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S06351A	S06351A	0
S06352A	S06352A	0
S06353A	S06353A	0
S06354A	S06354A	0
S06355A	S06355A	0
S06356A	S06356A	0
S06357A	S06357A	0
S06358A	S06358A	0
S06359A	S06359A	0

Diagnosis Code From	Diagnosis Code To	ICD Indicator
S06360A	S06360A	0
S06361A	S06361A	0
S06362A	S06362A	0
S06363A	S06363A	0
S06364A	S06364A	0
S06365A	S06365A	0
S06366A	S06366A	0
S06367A	S06367A	0
S06368A	S06368A	0
S06369A	S06369A	0
S06370A	S06370A	0
S06371A	S06371A	0
S06372A	S06372A	0
S06373A	S06373A	0
S06374A	S06374A	0
S06375A	S06375A	0
S06376A	S06376A	0
S06377A	S06377A	0
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S06379A	S06379A	0
S06380A	S06380A	0
S06381A	S06381A	0
S06382A	S06382A	0
S06383A	S06383A	0
S06384A	S06384A	0
S06385A	S06385A	0
S06386A	S06386A	0
S06387A	S06387A	0
S06388A	S06388A	0
S06389A	S06389A	0
S064X0A	S064X0A	0
S064X1A	S064X1A	0
S064X2A	S064X2A	0
S064X3A	S064X3A	0
S064X4A	S064X4A	0
S064X5A	S064X5A	0
S064X6A	S064X6A	0
S064X7A	S064X7A	0
S064X8A	S064X8A	0

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Diagnosis Code From	Diagnosis Code To	ICD Indicator
S064X9A	S064X9A	0
S065X0A	S065X0A	0
S065X1A	S065X1A	0
S065X2A	S065X2A	0
S065X3A	S065X3A	0
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S065X5A	S065X5A	0
S065X6A	S065X6A	0
S065X7A	S065X7A	0
S065X8A	S065X8A	0
S065X9A	S065X9A	0
S066X0A	S066X0A	0
S066X1A	S066X1A	0
S066X2A	S066X2A	0
S066X3A	S066X3A	0
S066X4A	S066X4A	0
S066X5A	S066X5A	0
S066X6A	S066X6A	0
S066X7A	S066X7A	0
S066X8A	S066X8A	0
S066X9A	S066X9A	0
S06810A	S06810A	0
S06811A	S06811A	0
S06812A	S06812A	0
S06813A	S06813A	0
S06814A	S06814A	0
S06815A	S06815A	0
S06816A	S06816A	0
S06817A	S06817A	0
S06818A	S06818A	0
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S06820A	S06820A	0
S06821A	S06821A	0
S06822A	S06822A	0
S06823A	S06823A	0
S06824A	S06824A	0
S06825A	S06825A	0
S06826A	S06826A	0

Diagnosis Code From	Diagnosis Code To	ICD Indicator
S06827A	S06827A	0
S06828A	S06828A	0
S06829A	S06829A	0
S06890A	S06890A	0
S06891A	S06891A	0
S06892A	S06892A	0
S06893A	S06893A	0
S06894A	S06894A	0
S06895A	S06895A	0
S06896A	S06896A	0
S06897A	S06897A	0
S06898A	S06898A	0
S06899A	S06899A	0
S069X0A	S069X0A	0
S069X1A	S069X1A	0
S069X2A	S069X2A	0
S069X3A	S069X3A	0
S069X4A	S069X4A	0
S069X5A	S069X5A	0
S069X6A	S069X6A	0
S069X7A	S069X7A	0
S069X8A	S069X8A	0
S069X9A	S069X9A	0
S070XXA	S070XXA	0
S071XXA	S071XXA	0
S078XXA	S078XXA	0
S079XXA	S079XXA	0
S11011A	S11011A	0
S11012A	S11012A	0
S11013A	S11013A	0
S11014A	S11014A	0
S11015A	S11015A	0
S11019A	S11019A	0
S11021A	S11021A	0
S11022A	S11022A	0
S11023A	S11023A	0
S11024A	S11024A	0
S11025A	S11025A	0

Diagnosis Code From	Diagnosis Code To	ICD Indicator
S11029A	S11029A	0
S11031A	S11031A	0
S11032A	S11032A	0
S11033A	S11033A	0
S11034A	S11034A	0
S11035A	S11035A	0
S11039A	S11039A	0
S1110XA	S1110XA	0
S1111XA	S1111XA	0
S1112XA	S1112XA	0
S1113XA	S1113XA	0
S1114XA	S1114XA	0
S1115XA	S1115XA	0
S1120XA	S1120XA	0
S1121XA	S1121XA	0
S1122XA	S1122XA	0
S1123XA	S1123XA	0
S1124XA	S1124XA	0
S1125XA	S1125XA	0
S12000A	S12000B	0
S12001A	S12001B	0
S1201XA	S1201XB	0
S1202XA	S1202XB	0
S12030A	S12030B	0
S12031A	S12031B	0
S12040A	S12040B	0
S12041A	S12041B	0
S12090A	S12090B	0
S12091A	S12091B	0
S12100A	S12100B	0
S12101A	S12101B	0
S12110A	S12110B	0
S12111A	S12111B	0
S12112A	S12112B	0
S12120A	S12120B	0
S12121A	S12121B	0
S12130A	S12130B	0
S12131A	S12131B	0

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Diagnosis Code From	Diagnosis Code To	ICD Indicator
S1214XA	S1214XB	0
S12150A	S12150B	0
S12151A	S12151B	0
S12190A	S12190B	0
S12191A	S12191B	0
S12200A	S12200B	0
S12201A	S12201B	0
S12230A	S12230B	0
S12231A	S12231B	0
S1224XA	S1224XB	0
S12250A	S12250B	0
S12251A	S12251B	0
S12290A	S12290B	0
S12291A	S12291B	0
S12300A	S12300B	0
S12301A	S12301B	0
S12330A	S12330B	0
S12331A	S12331B	0
S1234XA	S1234XB	0
S12350A	S12350B	0
S12351A	S12351B	0
S12390A	S12390B	0
S12391A	S12391B	0
S12400A	S12400B	0
S12401A	S12401B	0
S12430A	S12430B	0
S12431A	S12431B	0
S1244XA	S1244XB	0
S12450A	S12450B	0
S12451A	S12451B	0
S12490A	S12490B	0
S12491A	S12491B	0
S12500A	S12500B	0
S12501A	S12501B	0
S12530A	S12530B	0
S12531A	S12531B	0
S1254XA	S1254XB	0
S12550A	S12550B	0
S12551A	S12551B	0

Diagnosis Code From	Diagnosis Code To	ICD Indicator
S12590A	S12590B	0
S12591A	S12591B	0
S12600A	S12600B	0
S12601A	S12601B	0
S12630A	S12630B	0
S12631A	S12631B	0
S1264XA	S1264XB	0
S12650A	S12650B	0
S12651A	S12651B	0
S12690A	S12690B	0
S12691A	S12691B	0
S128XXA	S128XXA	0
S129XXA	S129XXA	0
S13171A	S13171A	0
S140XXA	S140XXA	0
S14101A	S14101A	0
S14102A	S14102A	0
S14103A	S14103A	0
S14104A	S14104A	0
S14105A	S14105A	0
S14106A	S14106A	0
S14107A	S14107A	0
S14108A	S14108A	0
S14109A	S14109A	0
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S14113A	S14113A	0
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S14115A	S14115A	0
S14116A	S14116A	0
S14117A	S14117A	0
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S14121A	S14121A	0
S14122A	S14122A	0
S14123A	S14123A	0
S14124A	S14124A	0
S14125A	S14125A	0
S14126A	S14126A	0
S14127A	S14127A	0

Diagnosis Code From	Diagnosis Code To	ICD Indicator
S14128A	S14128A	0
S14131A	S14131A	0
S14132A	S14132A	0
S14133A	S14133A	0
S14134A	S14134A	0
S14135A	S14135A	0
S14136A	S14136A	0
S14137A	S14137A	0
S14138A	S14138A	0
S14141A	S14141A	0
S14142A	S14142A	0
S14143A	S14143A	0
S14144A	S14144A	0
S14145A	S14145A	0
S14146A	S14146A	0
S14147A	S14147A	0
S14148A	S14148A	0
S14151A	S14151A	0
S14152A	S14152A	0
S14153A	S14153A	0
S14154A	S14154A	0
S14155A	S14155A	0
S14156A	S14156A	0
S14157A	S14157A	0
S14158A	S14158A	0
S170XXA	S170XXA	0
S178XXA	S178XXA	0
S179XXA	S179XXA	0
S21021A	S21021A	0
S21022A	S21022A	0
S21029A	S21029A	0
S21041A	S21041A	0
S21042A	S21042A	0
S21049A	S21049A	0
S21101A	S21101A	0
S21102A	S21102A	0
S21109A	S21109A	0
S21111A	S21111A	0
S21112A	S21112A	0

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Diagnosis Code From	Diagnosis Code To	ICD Indicator
S21119A	S21119A	0
S21121A	S21121A	0
S21122A	S21122A	0
S21129A	S21129A	0
S21131A	S21131A	0
S21132A	S21132A	0
S21139A	S21139A	0
S21141A	S21141A	0
S21142A	S21142A	0
S21149A	S21149A	0
S21151A	S21151A	0
S21152A	S21152A	0
S21159A	S21159A	0
S21201A	S21201A	0
S21202A	S21202A	0
S21209A	S21209A	0
S21211A	S21211A	0
S21212A	S21212A	0
S21219A	S21219A	0
S21221A	S21221A	0
S21222A	S21222A	0
S21229A	S21229A	0
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S21232A	S21232A	0
S21239A	S21239A	0
S21241A	S21241A	0
S21242A	S21242A	0
S21249A	S21249A	0
S21251A	S21251A	0
S21252A	S21252A	0
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S21301A	S21301A	0
S21302A	S21302A	0
S21309A	S21309A	0
S21311A	S21311A	0
S21312A	S21312A	0
S21319A	S21319A	0
S21321A	S21321A	0

Diagnosis Code From	Diagnosis Code To	ICD Indicator
S21322A	S21322A	0
S21329A	S21329A	0
S21331A	S21331A	0
S21332A	S21332A	0
S21339A	S21339A	0
S21341A	S21341A	0
S21342A	S21342A	0
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S21351A	S21351A	0
S21352A	S21352A	0
S21359A	S21359A	0
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S21441A	S21441A	0
S21442A	S21442A	0
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S21451A	S21451A	0
S21452A	S21452A	0
S21459A	S21459A	0
S2190XA	S2190XA	0
S2191XA	S2191XA	0
S2192XA	S2192XA	0
S2193XA	S2193XA	0
S2194XA	S2194XA	0
S2195XA	S2195XA	0
S22000A	S22000B	0
S22001A	S22001B	0
S22002A	S22002B	0

Diagnosis Code From	Diagnosis Code To	ICD Indicator
S22008A	S22008B	0
S22009A	S22009B	0
S22010A	S22010B	0
S22011A	S22011B	0
S22012A	S22012B	0
S22018A	S22018B	0
S22019A	S22019B	0
S22020A	S22020B	0
S22021A	S22021B	0
S22022A	S22022B	0
S22028A	S22028B	0
S22029A	S22029B	0
S22030A	S22030B	0
S22031A	S22031B	0
S22032A	S22032B	0
S22038A	S22038B	0
S22039A	S22039B	0
S22040A	S22040B	0
S22041A	S22041B	0
S22042A	S22042B	0
S22048A	S22048B	0
S22049A	S22049B	0
S22050A	S22050B	0
S22051A	S22051B	0
S22052A	S22052B	0
S22058A	S22058B	0
S22059A	S22059B	0
S22060A	S22060B	0
S22061A	S22061B	0
S22062A	S22062B	0
S22068A	S22068B	0
S22069A	S22069B	0
S22070A	S22070B	0
S22071A	S22071B	0
S22072A	S22072B	0
S22078A	S22078B	0
S22079A	S22079B	0
S22080A	S22080B	0

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Diagnosis Code From	Diagnosis Code To	ICD Indicator
S22081A	S22081B	0
S22082A	S22082B	0
S22088A	S22088B	0
S22089A	S22089B	0
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S2222XA	S2222XB	0
S2223XA	S2223XB	0
S2224XA	S2224XB	0
S2231XA	S2231XB	0
S2232XA	S2232XB	0
S2239XA	S2239XB	0
S2241XA	S2241XB	0
S2242XA	S2242XB	0
S2243XA	S2243XB	0
S2249XA	S2249XB	0
S225XXA	S225XXB	0
S229XXA	S229XXB	0
S240XXA	S240XXA	0
S24101A	S24101A	0
S24102A	S24102A	0
S24103A	S24103A	0
S24104A	S24104A	0
S24109A	S24109A	0
S24111A	S24111A	0
S24112A	S24112A	0
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S2692XA	S2692XA	0
S2699XA	S2699XA	0
S270XXA	S270XXA	0
S271XXA	S271XXA	0
S272XXA	S272XXA	0
S27301A	S27301A	0
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S27899A	S27899A	0
S279XXA	S279XXA	0
S280XXA	S280XXA	0
S281XXA	S281XXA	0
S29021A	S29021A	0
S29022A	S29022A	0
S29029A	S29029A	0
S31000A	S31000A	0
S31001A	S31001A	0
S31010A	S31010A	0
S31011A	S31011A	0

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Diagnosis Code From	Diagnosis Code To	ICD Indicator
S31020A	S31020A	0
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S31030A	S31030A	0
S31031A	S31031A	0
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S31041A	S31041A	0
S31050A	S31050A	0
S31051A	S31051A	0
S31100A	S31100A	0
S31101A	S31101A	0
S31102A	S31102A	0
S31103A	S31103A	0
S31104A	S31104A	0
S31105A	S31105A	0
S31109A	S31109A	0
S31110A	S31110A	0
S31111A	S31111A	0
S31112A	S31112A	0
S31113A	S31113A	0
S31114A	S31114A	0
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S31141A	S31141A	0
S31142A	S31142A	0
S31143A	S31143A	0
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S3135XA	S3135XA	0
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S3142XA	S3142XA	0
S3143XA	S3143XA	0
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S3145XA	S3145XA	0
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S31601A	S31601A	0
S31602A	S31602A	0
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S31652A	S31652A	0
S31653A	S31653A	0
S31654A	S31654A	0
S31655A	S31655A	0
S31659A	S31659A	0
S31802A	S31802A	0
S31804A	S31804A	0
S31812A	S31812A	0
S31814A	S31814A	0

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Diagnosis Code From	Diagnosis Code To	ICD Indicator
S31822A	S31822A	0
S31824A	S31824A	0
S32000A	S32000B	0
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S32002A	S32002B	0
S32008A	S32008B	0
S32009A	S32009B	0
S32010A	S32010B	0
S32011A	S32011B	0
S32012A	S32012B	0
S32018A	S32018B	0
S32019A	S32019B	0
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S32022A	S32022B	0
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S32110A	S32110B	0
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S32112A	S32112B	0
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S32120A	S32120B	0
S32121A	S32121B	0

Diagnosis Code From	Diagnosis Code To	ICD Indicator
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S3219XA	S3219XB	0
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S32301A	S32301B	0
S32302A	S32302B	0
S32309A	S32309B	0
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S32423A	S32423B	0
S32424A	S32424B	0
S32425A	S32425B	0
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Diagnosis Code From	Diagnosis Code To	ICD Indicator
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S32433A	S32433B	0
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S32492A	S32492B	0
S32499A	S32499B	0

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Diagnosis Code From	Diagnosis Code To	ICD Indicator
S32501A	S32501B	0
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S32509A	S32509B	0
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S32591A	S32591B	0
S32592A	S32592B	0
S32599A	S32599B	0
S32601A	S32601B	0
S32602A	S32602B	0
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S32616A	S32616B	0
S32691A	S32691B	0
S32692A	S32692B	0
S32699A	S32699B	0
S32810A	S32810B	0
S32811A	S32811B	0
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S3289XA	S3289XB	0
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S34111A	S34111A	0
S34112A	S34112A	0
S34113A	S34113A	0
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Diagnosis Code From	Diagnosis Code To	ICD Indicator
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S36032A	S36032A	0
S36039A	S36039A	0
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S36501A	S36501A	0
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S36508A	S36508A	0
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Diagnosis Code From	Diagnosis Code To	ICD Indicator
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S36899A	S36899A	0
S3690XA	S3690XA	0
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S3720XA	S3720XA	0
S3730XA	S3730XA	0
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Diagnosis Code From	Diagnosis Code To	ICD Indicator
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S37591A	S37591A	0
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S3763XA	S3763XA	0
S3769XA	S3769XA	0
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S38002A	S38002A	0
S3801XA	S3801XA	0
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S3803XA	S3803XA	0
S381XXA	S381XXA	0
S38221A	S38221A	0
S38222A	S38222A	0
S38231A	S38231A	0
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S41029A	S41029A	0
S41041A	S41041A	0

Diagnosis Code From	Diagnosis Code To	ICD Indicator
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S42112A	S42112B	0
S42113A	S42113B	0

Diagnosis Code From	Diagnosis Code To	ICD Indicator
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S42213A	S42213B	0
S42214A	S42214B	0
S42215A	S42215B	0
S42216A	S42216B	0

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Diagnosis Code From	Diagnosis Code To	ICD Indicator
S42221A	S42221B	0
S42222A	S42222B	0
S42223A	S42223B	0
S42224A	S42224B	0
S42225A	S42225B	0
S42226A	S42226B	0
S42231A	S42231B	0
S42232A	S42232B	0
S42239A	S42239B	0
S42241A	S42241B	0
S42242A	S42242B	0
S42249A	S42249B	0
S42251A	S42251B	0
S42252A	S42252B	0
S42253A	S42253B	0
S42254A	S42254B	0
S42255A	S42255B	0
S42256A	S42256B	0
S42261A	S42261B	0
S42262A	S42262B	0
S42263A	S42263B	0
S42264A	S42264B	0
S42265A	S42265B	0
S42266A	S42266B	0
S42271A	S42271A	0
S42272A	S42272A	0
S42279A	S42279A	0
S42291A	S42291B	0
S42292A	S42292B	0
S42293A	S42293B	0
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S42295A	S42295B	0
S42296A	S42296B	0
S42301A	S42301B	0
S42302A	S42302B	0
S42309A	S42309B	0
S42311A	S42311A	0
S42312A	S42312A	0

Diagnosis Code From	Diagnosis Code To	ICD Indicator
S42319A	S42319A	0
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S42322A	S42322B	0
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S42324A	S42324B	0
S42325A	S42325B	0
S42326A	S42326B	0
S42331A	S42331B	0
S42332A	S42332B	0
S42333A	S42333B	0
S42334A	S42334B	0
S42335A	S42335B	0
S42336A	S42336B	0
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S42346A	S42346B	0
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S42392A	S42392B	0
S42399A	S42399B	0
S42401A	S42401B	0
S42402A	S42402B	0
S42409A	S42409B	0
S42411A	S42411B	0

Diagnosis Code From	Diagnosis Code To	ICD Indicator
S42412A	S42412B	0
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S42414A	S42414B	0
S42415A	S42415B	0
S42416A	S42416B	0
S42421A	S42421B	0
S42422A	S42422B	0
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S42451A	S42451B	0
S42452A	S42452B	0
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S42454A	S42454B	0
S42455A	S42455B	0
S42456A	S42456B	0
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S42462A	S42462B	0
S42463A	S42463B	0
S42464A	S42464B	0
S42465A	S42465B	0
S42466A	S42466B	0

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Diagnosis Code From	Diagnosis Code To	ICD Indicator
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S42473A	S42473B	0
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S42476A	S42476B	0
S42481A	S42481A	0
S42482A	S42482A	0
S42489A	S42489A	0
S42491A	S42491B	0
S42492A	S42492B	0
S42493A	S42493B	0
S42494A	S42494B	0
S42495A	S42495B	0
S42496A	S42496B	0
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S4292XA	S4292XB	0
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S46829A	S46829A	0
S46921A	S46921A	0
S46922A	S46922A	0
S46929A	S46929A	0
S471XXA	S471XXA	0
S472XXA	S472XXA	0
S479XXA	S479XXA	0

Diagnosis Code From	Diagnosis Code To	ICD Indicator
S48011A	S48011A	0
S48012A	S48012A	0
S48019A	S48019A	0
S48021A	S48021A	0
S48022A	S48022A	0
S48029A	S48029A	0
S48111A	S48111A	0
S48112A	S48112A	0
S48119A	S48119A	0
S48121A	S48121A	0
S48122A	S48122A	0
S48129A	S48129A	0
S48911A	S48911A	0
S48912A	S48912A	0
S48919A	S48919A	0
S48921A	S48921A	0
S48922A	S48922A	0
S48929A	S48929A	0
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S49002A	S49002A	0
S49009A	S49009A	0
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S49012A	S49012A	0
S49019A	S49019A	0
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S49022A	S49022A	0
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S49049A	S49049A	0
S49091A	S49091A	0
S49092A	S49092A	0
S49099A	S49099A	0
S49101A	S49101A	0
S49102A	S49102A	0
S49109A	S49109A	0

Diagnosis Code From	Diagnosis Code To	ICD Indicator
S49111A	S49111A	0
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S49122A	S49122A	0
S49129A	S49129A	0
S49131A	S49131A	0
S49132A	S49132A	0
S49139A	S49139A	0
S49141A	S49141A	0
S49142A	S49142A	0
S49149A	S49149A	0
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S49192A	S49192A	0
S49199A	S49199A	0
S51001A	S51001A	0
S51002A	S51002A	0
S51009A	S51009A	0
S51011A	S51011A	0
S51012A	S51012A	0
S51019A	S51019A	0
S51021A	S51021A	0
S51022A	S51022A	0
S51029A	S51029A	0
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S51032A	S51032A	0
S51039A	S51039A	0
S51041A	S51041A	0
S51042A	S51042A	0
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S51051A	S51051A	0
S51052A	S51052A	0
S51059A	S51059A	0
S51801A	S51801A	0
S51802A	S51802A	0
S51809A	S51809A	0
S51811A	S51811A	0
S51812A	S51812A	0
S51819A	S51819A	0

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Diagnosis Code From	Diagnosis Code To	ICD Indicator
S51821A	S51821A	0
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S51829A	S51829A	0
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S51851A	S51851A	0
S51852A	S51852A	0
S51859A	S51859A	0
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S52009A	S52009C	0
S52011A	S52011A	0
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S52301A	S52301C	0
S52302A	S52302C	0
S52309A	S52309C	0
S52311A	S52311A	0
S52312A	S52312A	0
S52319A	S52319A	0
S52321A	S52321C	0
S52322A	S52322C	0
S52323A	S52323C	0

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Diagnosis Code From	Diagnosis Code To	ICD Indicator
S52324A	S52324C	0
S52325A	S52325C	0
S52326A	S52326C	0
S52331A	S52331C	0
S52332A	S52332C	0
S52333A	S52333C	0
S52334A	S52334C	0
S52335A	S52335C	0
S52336A	S52336C	0
S52341A	S52341C	0
S52342A	S52342C	0
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S52392A	S52392C	0
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S52515A	S52515C	0
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S52532A	S52532C	0
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S52542A	S52542C	0
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S52614A	S52614C	0
S52615A	S52615C	0
S52616A	S52616C	0
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Diagnosis Code From	Diagnosis Code To	ICD Indicator
S56921A	S56921A	0
S56922A	S56922A	0
S56929A	S56929A	0
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S5701XA	S5701XA	0
S5702XA	S5702XA	0
S5780XA	S5780XA	0
S5781XA	S5781XA	0
S5782XA	S5782XA	0
S58011A	S58011A	0
S58012A	S58012A	0
S58019A	S58019A	0
S58021A	S58021A	0
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S58029A	S58029A	0
S58111A	S58111A	0
S58112A	S58112A	0
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S61559A	S61559A	0
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S62011A	S62011B	0
S62012A	S62012B	0
S62013A	S62013B	0
S62014A	S62014B	0
S62015A	S62015B	0

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Diagnosis Code From	Diagnosis Code To	ICD Indicator
S62016A	S62016B	0
S62021A	S62021B	0
S62022A	S62022B	0
S62023A	S62023B	0
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S72026A	S72026C	0

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Diagnosis Code From	Diagnosis Code To	ICD Indicator
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S82009A	S82009C	0
S82011A	S82011C	0

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Diagnosis Code From	Diagnosis Code To	ICD Indicator
S82012A	S82012C	0
S82013A	S82013C	0
S82014A	S82014C	0
S82015A	S82015C	0
S82016A	S82016C	0
S82021A	S82021C	0
S82022A	S82022C	0
S82023A	S82023C	0
S82024A	S82024C	0
S82025A	S82025C	0
S82026A	S82026C	0
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S82036A	S82036C	0
S82041A	S82041C	0
S82042A	S82042C	0
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S82044A	S82044C	0
S82045A	S82045C	0
S82046A	S82046C	0
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S82109A	S82109C	0
S82111A	S82111C	0
S82112A	S82112C	0
S82113A	S82113C	0
S82114A	S82114C	0
S82115A	S82115C	0
S82116A	S82116C	0
S82121A	S82121C	0
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S82392A	S82392C	0
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S82401A	S82401C	0
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S82409A	S82409C	0
S82421A	S82421C	0

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Diagnosis Code From	Diagnosis Code To	ICD Indicator
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S82424A	S82424C	0
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S8256XA	S8256XC	0
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S8263XA	S8263XC	0
S8264XA	S8264XC	0
S8265XA	S8265XC	0
S8266XA	S8266XC	0
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S82812A	S82812A	0
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S82892A	S82892C	0
S82899A	S82899C	0
S8290XA	S8290XC	0
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S8292XA	S8292XC	0
S86021A	S86021A	0
S86022A	S86022A	0
S86029A	S86029A	0
S86121A	S86121A	0
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S86129A	S86129A	0
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S86321A	S86321A	0
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S86922A	S86922A	0
S86929A	S86929A	0
S8700XA	S8700XA	0
S8701XA	S8701XA	0
S8702XA	S8702XA	0
S8780XA	S8780XA	0
S8781XA	S8781XA	0
S8782XA	S8782XA	0
S88011A	S88011A	0
S88012A	S88012A	0
S88019A	S88019A	0
S88021A	S88021A	0
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S88029A	S88029A	0
S88111A	S88111A	0
S88112A	S88112A	0
S88119A	S88119A	0
S88121A	S88121A	0

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Diagnosis Code From	Diagnosis Code To	ICD Indicator
S88122A	S88122A	0
S88129A	S88129A	0
S88911A	S88911A	0
S88912A	S88912A	0
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S89001A	S89001A	0
S89002A	S89002A	0
S89009A	S89009A	0
S89011A	S89011A	0
S89012A	S89012A	0
S89019A	S89019A	0
S89021A	S89021A	0
S89022A	S89022A	0
S89029A	S89029A	0
S89031A	S89031A	0
S89032A	S89032A	0
S89039A	S89039A	0
S89041A	S89041A	0
S89042A	S89042A	0
S89049A	S89049A	0
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S89121A	S89121A	0
S89122A	S89122A	0
S89129A	S89129A	0
S89131A	S89131A	0
S89132A	S89132A	0
S89139A	S89139A	0

Diagnosis Code From	Diagnosis Code To	ICD Indicator
S89141A	S89141A	0
S89142A	S89142A	0
S89149A	S89149A	0
S89191A	S89191A	0
S89192A	S89192A	0
S89199A	S89199A	0
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S89219A	S89219A	0
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S89311A	S89311A	0
S89312A	S89312A	0
S89319A	S89319A	0
S89321A	S89321A	0
S89322A	S89322A	0
S89329A	S89329A	0
S89391A	S89391A	0
S89392A	S89392A	0
S89399A	S89399A	0
S91009A	S91009A	0
S91021A	S91021A	0
S91022A	S91022A	0
S91029A	S91029A	0
S91041A	S91041A	0
S91042A	S91042A	0
S91049A	S91049A	0
S92001A	S92001B	0

Diagnosis Code From	Diagnosis Code To	ICD Indicator
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S92036A	S92036B	0
S92041A	S92041B	0
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S92054A	S92054B	0
S92055A	S92055B	0
S92056A	S92056B	0
S92061A	S92061B	0
S92062A	S92062B	0
S92063A	S92063B	0
S92064A	S92064B	0
S92065A	S92065B	0
S92066A	S92066B	0

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Diagnosis Code From	Diagnosis Code To	ICD Indicator
S92101A	S92101B	0
S92102A	S92102B	0
S92109A	S92109B	0
S92111A	S92111B	0
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S92121A	S92121B	0
S92122A	S92122B	0
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S92126A	S92126B	0
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S92143A	S92143B	0
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S92145A	S92145B	0
S92146A	S92146B	0
S92151A	S92151B	0
S92152A	S92152B	0
S92153A	S92153B	0
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S92156A	S92156B	0
S92191A	S92191B	0
S92192A	S92192B	0
S92199A	S92199B	0
S92201A	S92201B	0
S92202A	S92202B	0
S92209A	S92209B	0

Diagnosis Code From	Diagnosis Code To	ICD Indicator
S92211A	S92211B	0
S92212A	S92212B	0
S92213A	S92213B	0
S92214A	S92214B	0
S92215A	S92215B	0
S92216A	S92216B	0
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Diagnosis Code From	Diagnosis Code To	ICD Indicator
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S92322A	S92322B	0
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S92423A	S92423B	0

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Diagnosis Code From	Diagnosis Code To	ICD Indicator
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S92491A	S92491B	0
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Diagnosis Code From	Diagnosis Code To	ICD Indicator
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S9780XA	S9780XA	0
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S9782XA	S9782XA	0
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Diagnosis Code From	Diagnosis Code To	ICD Indicator
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T17318A	T17318A	0
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T17328A	T17328A	0
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T17410A	T17410A	0
T17418A	T17418A	0
T17420A	T17420A	0
T17428A	T17428A	0
T17490A	T17490A	0
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T17808A	T17808A	0
T17810A	T17810A	0
T17818A	T17818A	0
T17820A	T17820A	0
T17828A	T17828A	0
T17890A	T17890A	0
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T2020XA	T2020XA	0
T20211A	T20211A	0
T20212A	T20212A	0

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Diagnosis Code From	Diagnosis Code To	ICD Indicator
T20219A	T20219A	0
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T2023XA	T2023XA	0
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T20612A	T20612A	0
T20619A	T20619A	0
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T20719A	T20719A	0
T2072XA	T2072XA	0
T2073XA	T2073XA	0
T2074XA	T2074XA	0
T2075XA	T2075XA	0
T2076XA	T2076XA	0

Diagnosis Code From	Diagnosis Code To	ICD Indicator
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T2131XA	T2131XA	0
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T2134XA	T2134XA	0
T2135XA	T2135XA	0
T2136XA	T2136XA	0
T2137XA	T2137XA	0
T2139XA	T2139XA	0
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T22232A	T22232A	0
T22239A	T22239A	0
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T22251A	T22251A	0
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T22261A	T22261A	0
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Diagnosis Code From	Diagnosis Code To	ICD Indicator
T22291A	T22291A	0
T22292A	T22292A	0
T22299A	T22299A	0
T2230XA	T2230XA	0
T22311A	T22311A	0
T22312A	T22312A	0
T22319A	T22319A	0
T22321A	T22321A	0
T22322A	T22322A	0
T22329A	T22329A	0
T22331A	T22331A	0
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T22362A	T22362A	0
T22369A	T22369A	0
T22391A	T22391A	0
T22392A	T22392A	0
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T22631A	T22631A	0
T22632A	T22632A	0
T22639A	T22639A	0
T22641A	T22641A	0
T22642A	T22642A	0
T22649A	T22649A	0
T22651A	T22651A	0

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Diagnosis Code From	Diagnosis Code To	ICD Indicator
T22652A	T22652A	0
T22659A	T22659A	0
T22661A	T22661A	0
T22662A	T22662A	0
T22669A	T22669A	0
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T22692A	T22692A	0
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T22732A	T22732A	0
T22739A	T22739A	0
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T22742A	T22742A	0
T22749A	T22749A	0
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T23312A	T23312A	0
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Diagnosis Code From	Diagnosis Code To	ICD Indicator
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T23332A	T23332A	0
T23339A	T23339A	0
T23341A	T23341A	0
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T23742A	T23742A	0
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T24791A	T24791A	0
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T24799A	T24799A	0

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T25311A	T25311A	0
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T7509XA	T7509XA	0
T751XXA	T751XXA	0
T754XXA	T754XXA	0

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Diagnosis Code From	Diagnosis Code To	ICD Indicator
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T796XXA	T796XXA	0
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T82828A	T82828A	0
T82838A	T82838A	0
T82848A	T82848A	0
T82858A	T82858A	0

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T82898A	T82898A	0
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T84048A	T84048A	0
T84049A	T84049A	0
T886XXA	T886XXA	0
T888XXA	T888XXA	0
X58XXXA	X58XXXA	0

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Quarterly Revision April 2024

This table contains a listing of pages containing changes made to the *Alabama Medicaid Provider Manual.* This version replaces the entire manual.

To update your paper copy of the manual, replace the entire manual.

Changes have been tracked throughout the provider manual and noted in the margins. Additions are easily identified by underlines and deletions by a ~~strikethrough~~.

To request additional copies of the *Alabama Medicaid Provider Manual*, contact the Gainwell Provider Assistance Center by calling 1(800) 688-7989.

You can also go to http://www.medicaid.alabama.gov to download a complete, updated, electronic version of the *Alabama Medicaid Provider Manual* from Medicaid's web site.

Find out more about the online version of the *Alabama Medicaid Provider Manual* in Chapter 1, Section 1.2, Using the Online Version of the Manual.

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