39

39 Patient 1st

The **Patient 1st** Manual has been developed by the Alabama Medicaid Agency to explain the policies and procedures of the Patient 1st program. Every effort has been made to present qualified providers a comprehensive guide to basic information concerning program requirements and billing procedures. The policies outlined in this manual are binding upon the provider. Providers should also refer to the DXC Provider Insider as well as any letters, transmittals or ALERTS regarding any updates or changes within this program.

If you have any questions about this program please contact the Provider Assistance Center at 1 (800) 688-7989.

39.1 Overview

The goal of Patient 1st is to create patient centered, quality focused care through a medical home by linking Medicaid recipients with a primary medical provider (PMP). The PMP coordinates care for recipients by providing and arranging for each recipients health care needs. Enrolling recipients into a medical home reduces the need for recipients to seek basic sick care services from a hospital emergency department, reduces duplicative care and optimizes appropriate care delivery.

Health Homes were implemented statewide April 1, 2015 to assist Patient 1st PMPs in coordinating care of patients with the following chronic conditions: Mental Health Condition, Substance Abuse Disorders, Asthma, Diabetes, Heart Disease, Cancer, Cardiovascular Disease, Chronic Obstructive Pulmonary Disease, HIV with a look back of claims data 18 months, Sickle Cell Anemia, and Transplants with a look back of Medicaid claims data for five years, Hepatitis C and BMI over 25; by connecting patients with needed resources teaching self-management skills, providing transitional care, and bridging medical and behavioral services. In addition, the Health Homes coordinate medical management meetings with the PMPs to provide education on the health needs of the community and initiatives based on analytical data.

Patient 1st operates pursuant to an approved State Plan authority granted under section 1932(a)(1)(A) of the Social Security Act. PMPs receive a monthly case management fee per member, per month for coordinating the care of Medicaid recipients enrolled with their practice. Direct services are reimbursed fee-for-service.

Patient 1st can be successful only with the commitment of the provider community. To ensure an adequate provider base, the Alabama Medicaid Agency (Medicaid) executes provider agreements with physicians who wish to participate in the **Patient 1st** Program on a continuous basis. The physician acting as a PMP agrees to abide by all existing laws, regulations and procedures pursuant to the **Patient 1st** Program and Medicaid participation.

39.2 Eligible Primary Medical Providers (PMPs)

39.2.1 Enrollment

Alabama Medicaid providers who are interested in participating as an individual Patient 1st provider must complete and submit a **Patient 1st Application Package** (application and agreement) to:

DXC Provider Enrollment Unit
301 Technacenter Drive
Montgomery, AL 36117

or

P.O. Box 241685
Montgomery, AL 36124

A copy of the application package is available on Medicaid's website at www.medicaid.alabama.gov.

The following provider types are eligible to participate as a PMP for the Patient 1st Program:

- Family Practitioners
- General Practitioners
- Pediatricians
- Internists
- OB/GYN

NOTE:

When in the best interest of a patient, a nontraditional PMP may be chosen (e.g., children with special health care needs). Other physicians may be considered for PMP participation if willing to meet all contractual requirements.

A participating physician in a clinic or health center may work at multiple sites. If a PMP wants a panel assignment at the remote site, those hours worked must be reported. Panel assignment at a remote site location can also be made based on midlevel extender hours.

The Patient 1st enrollee must be given information regarding the usual days and hours the physician is available for scheduled appointments. If a certified nurse practitioner or physician assistant cares for an enrollee, the enrollee must know the Patient 1st physician responsible for supervision. These obligations can be fulfilled through office signs, verbal instructions or written information.

The PMP has the option of being placed on the published or non-published PMP list. The PMP must indicate their preference when completing the Patient 1st Enrollment Form and will be indicated on the provider's monthly PMP Enrollment Roster, under Special Conditions. Regardless of publication, the PMP is included in the assignment process if caseload is available and criteria can be met.

The PMP list is sent to all new Patient 1st Medicaid recipients to assist them in selecting physicians/clinics serving their area. The PMP list, based by county, may also be accessed via the Medicaid web site at www.medicaid.alabama.gov. The list includes the PMP's county of participation, the PMP's name, specialty, physician extenders, physical address, phone numbers (regular, 24 hour and fax).

39.2.2 Caseload

The following standards apply to PMP caseloads:

- PMPs may participate in multiple sites; however, the maximum panel a PMP can serve is 1,200 (in most instances).
- Full time Physician Extenders (Nurse Practitioners (NPs) and Physician Assistants (PAs) will allow the caseload to be extended by up to 400 additional patients per extender. Physician Extenders per Physician will align with the requirements of the Alabama Board of Medical Examiner's Administrative Code for Qualifications and Limitations of Physician's and Physician Extenders (e.g. nurse practitioners, physician assistants).Currently, four (4) Physician Extenders per physician will be allowed.
- The PMP must practice a minimum of 36 hours per week to be considered full time.
- If less than full time, a percentage of a total patient caseload will be allowed, based on hours worked by PMP.

Examples:

Maximum Hours Worked by PMP in Designated primary and/or Remote Practice Site(s) Maximum Recipients Assigned

40 Hours	FTE = 1200 recipients
36 Hours	FTE = 1125 recipients
32 Hours	FTE = 1000 recipients
28 Hours	FTE = 875 recipients
24 Hours	FTE = 750 recipients
20 Hours	FTE= 625 recipients
16 Hours	FTE= 500 recipients
12 Hours	FTE = 375 recipients
8 Hours	FTE = 250 recipients
4 Hours	FTE = 125 recipients

- All caseloads will be coordinated with Medicaid through DXC.
- Physician extenders (Nurse Practitioners and Physician Assistants) may allow the caseload to be extended based on eligible PMP and hours worked by the Physician Extender.

Maximum Hours Worked in Office/Clinic Maximum Recipients Assigned

40 Hours	FTE = 400 recipients
36 Hours	FTE = 360 recipients
32 Hours	FTE = 320 recipients
28 Hours	FTE = 280 recipients
24 Hours	FTE = 240 recipients
20 Hours	FTE = 200 recipients

16 Hours	FTE = 160 recipients
12 Hours	FTE = 120 recipients
8 Hours	FTE = 80 recipients
4 Hours	FTE = 40 recipients

- The number of physician extenders per physician allowed will be aligned with the Alabama Board of Medical Examiners Administrative Code for Qualifications and Limitations of Physician's and Physician Extenders. Patient 1st assignments will only be made to the physician's panel.

NOTE:

If a nontraditional PMP has been assigned based on a case need, the full time requirement will not apply.

If the PMP wishes to extend the caseload above 1200 or 2800 (with extenders), a written request from the PMP for an extension of the maximum caseload should be submitted in writing and must address the following:

- The PMP's name and NPI;
- The total number of enrollees over the maximum limit that the PMP is requesting;
- The reason for the request to extend the PMPs maximum limit;
- The length of time the PMP has been in practice;
- Other extenuating documentation and explanations that would justify the request for an extension of the PMPs maximum caseload.

The request can be submitted at the time the Provider Agreement is signed or at a later date by submitting the request to DXC via the online web portal on the Medicaid website.

** A PMP's caseload may be exceeded to accommodate sibling assignment, newborn assignment, or assignments for previously established patients (last PMP on file).

If the PMP wishes to decrease the number of enrollees, he/she must notify DXC Provider Enrollment in writing, at least thirty (30) days in advance of the planned decrease in enrollees to allow for enrollee reassignment. If the PMP wishes to increase the maximum number of enrollees within the caseload specifications, he/she must notify DXC Provider Enrollment in writing via the online web portal on the Medicaid website.

Individual or specific recipient additions must be submitted in writing on the requesting provider's letterhead and include the following information; the provider's name and NPI as enrolled in the Patient 1st Program, the recipient's name, Medicaid number and the city in which the recipient lives. These changes can be submitted via the online web portal on the Medicaid website.

Any changes made to the PMP's panel should be with the understanding that no individuals eligible to enroll in Patient 1st will be discriminated against on the basis of health status or the need for health care services.

Furthermore, the PMP must accept individuals in the order in which they apply without restriction up to the limits set by the PMP and the Agency.

39.2.3 PMP Disenrollment

The PMP's agreement to participate in the Patient 1st program may be terminated by either the PMP or Agency, with cause or by mutual consent; upon at least 30 days written notice and will be effective on the first day of the month, pursuant to processing deadlines.

NOTE:

DXC no longer accept paper updates/disenrollment forms. They are now electronically uploaded to the Web Portal in PDF format. Failure to provide a 30-day notice may preclude future participation opportunities and/or recoupment of case management fees.

A Disenrollment Request Form must be submitted by the PMP to Provider Enrollment at DXC with the disenrollment effective date. The Disenrollment Request Form can be found on www.medicaid.alabama.gov; Resources/Forms Library/Provider Enrollment. Scroll down to Administrative/Update Forms and Information.

If a PMP is leaving a practice, upon request, patients will be reassigned to another PMP within the group or outside the individual practice.

39.3 PMP Responsibilities

In order to participate as a PMP, the following requirements must be met. Detailed information is provided on specific requirements in subsequent sections.

39.3.1 Functions and Duties

The PMP shall comply with all applicable federal and state statutes and regulations, and all amendments thereto, that are in effect when the provider agreement is signed, or that come into effect during the term of the agreement. This includes, but is not limited to the approved State Plan and Title 42 of the Code of Federal Regulations.

The Patient 1st PMP agrees to do the following:

- Be a licensed physician, enrolled in the Alabama Medicaid Program, who has not been sanctioned.
- Accept enrollees and be listed as a PMP in the Patient 1st Directory for the purpose of providing care to enrollees and managing their health care needs through the Medical Home concept.
- Provide hospital admissions. (Refer to 39.3.2: *Hospital Admitting Privileges Requirement)*
- Provide primary care and patient care coordination services to each enrollee in accordance with the policies set forth in Medicaid Provider Manuals and Medicaid bulletins and as defined by Patient 1st policy

- Provide or arrange for primary care coordination and coverage for services, consultation or referral, and treatment for emergency medical conditions, twenty-four (24) hours per day, seven (7) days per week as defined by Patient 1st policy. Automatic referral to the hospital emergency department for services does not satisfy this requirement. PMPs must have at least one telephone line that is answered by the office staff during regular office hours.
- Provide EPSDT preventive care screenings to Medicaid eligible children age birth through 20. PMPs serving this population who do not provide EPSDT services are required to sign an agreement with another provider to provide EPSDT services. PMPs must retain a copy of this agreement in their files and must ensure that their records include information regarding the extent of these services.
- Maintain a unified patient medical record for each enrollee following the medical record documentation guideline as defined by Patient 1st policy.
- Promptly arrange referrals for medically necessary health care services that are not provided directly and document referral for specialty care in the medical record. Provide the authorization number (NPI) to the referring provider.
- Transfer the Patient 1st enrollee's medical record to the receiving provider upon the change of primary medical provider at the request of the new primary care provider and as authorized by the enrollee within 30 days of the date of the request. Note: Patients must request their records be transferred to the new PMP and must not be charged a fee for this service.

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- Authorize care for the enrollee or see the enrollee based on the standards of appointment availability as defined by Patient 1st policy.
- Refer for a second opinion as defined by Patient 1st policy.
- Review and use all enrollee utilization and cost reports provided by the Patient 1st program for the purpose of practice level utilization management and advise the Agency of errors, omissions, or discrepancies. Review and use the monthly enrollment report as required by Patient 1st policy.
- Participate with Agency utilization management, quality assessment, and administrative programs.
- Provide the Agency or its duly authorized representatives and appropriate Federal Agency representatives unlimited access (including onsite inspections and review) to all records relating to the provision of services under the provider agreement as required by Medicaid policy and 42 C.F.R. 431.107.
- Maintain reasonable standards of professional conduct and provide care in conformity with generally accepted medical practice following

national and regional clinical practice guidelines or guidelines approved by the Patient 1st Advisory Group.

- Notify the Agency of any and all changes to information provided on the initial application for participation. If such changes are not reported within 30 days of change, then future participation may be limited.
- Give written notice of termination of the contract, within 15 days after receipt of the termination notice, to each enrollee who received his or her primary care from, or was seen on a regular basis.

- Retain records in accordance with requirements of 45 C.F.R. 74 (3 years after the final payment is made and all pending matters are closed, plus additional time if an audit, litigation, or other legal action involving the records is started before or during the original 3 year period ends).
- Comply with all Federal and State laws and regulations including Title VI of the Civil Rights Act of 1964, Title IX of the Education of Amendments of 1972 (regarding education programs and activities), the Age Discrimination Act of 1975, the Rehabilitation Act of 1973, and the Americans with Disabilities Act.
- Receive prior approval from the Agency of any Patient 1st specific, or education materials prior to distribution.
- Make oral interpretation services available free of charge to each potential enrollee and enrollee. This applies to all non-English languages.

NOTE:

Recipients can obtain assistance with language interpretation by calling the Recipient Call Center at 1(800) 362-1504.

PMPs are prohibited from the following:

- Discriminating against individuals eligible to enroll on the basis of health status or the need for health care services.
- Discriminating against individuals eligible to enroll on the basis of race, color, or national origin and will not use any policy or practice that has the effect of discrimination on the basis of race, color, or national origin.
- Providing materials that make any assertion or statement (whether written or oral) that the recipient must enroll with the PMP in order to obtain benefits or in order not to lose benefits. Materials shall not make any assertion or statement that the PMP is endorsed by CMS, the Federal or State government or similar entity.
- Door-to-door, telephonic or any form of marketing.
- Knowingly engaging in a relationship with the following:
    1. An individual who is debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under

Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549; or

2. An individual who is an affiliate, as defined in the Federal Acquisition Regulation.

Note: The relationship is described as follows:

a. As a doctor, officer, partner of the PMP,

b. A person with beneficial ownership of more than five percent (5%) or more of the PMP's equity; or,

c. A person with an employment, consulting or other arrangement with the PMP for the provision of items and services which are significant and material to the PMP's contractual obligation with the Agency.

39.3.2 Hospital Admitting Privileges Requirement

- Patient 1st Primary Medical Provider (PMPs) are required to establish and maintain hospital admitting privileges or have a formal arrangement with another physician or group for the management of inpatient hospital admissions that addressed the needs of all enrollees or potential enrollees. If a PMP does not admit patients, then the *Patient 1st Hospital Admitting Agreement* form must be submitted to the Agency to address this requirement for participation.
- A formal arrangement is defined as a voluntary agreement between the Patient 1st PMP and the agreeable physician/group. The agreeable party is committing in writing to admit and coordinate medical care for the Patient 1st enrollee throughout the inpatient stay. Admitting privileges or the formal arrangement for inpatient hospital care must be maintained at a hospital that is within a distance of thirty (30) miles or forty-five minutes' drive time from the Patient 1st PMP's practice. If there is no hospital that meets the above geographical criteria, the hospital geographically closest to the Patient 1st PMP's practice will be accepted.
- Admissions through unassigned hospital-based call groups do not meet this requirement.
- Exception may be granted in cases where it is determined the benefits of a provider's participation outweigh the provider's inability to comply with this requirement.

39.3.3 24/7 Coverage Requirement

- PMPs must provide enrollees with after-hours coverage. It is important that patients be able to contact their PMP to receive instruction or care at all times so that care will be provided in the most appropriate manner to the patient's condition. After hours coverage must be available 24 hours a day every day of the year. PMP's can meet this requirement through a variety of methods. To qualify as a Patient 1st provider , one of the following must be met:
- The after-hours telephone number must connect the patient to the PMP or an authorized medical practitioner.

- The after-hours telephone number must connect the patient to a live voice call center system or answering service who will either direct the patient to the appropriate care site or contact the PMP or PMP authorized medical practitioner. If the PMP or authorized medical practitioner is contacted, then the patient should receive instructions within one (1) hour.
- The after-hours telephone number can connect to a hospital if the PMP has standing orders with the hospital to direct patients to the appropriate care site. (For example, if the patient's symptoms are such that the patient can be seen the next morning, the hospital should direct the patient to contact the PMP in the morning to make an appointment).

An office telephone line that is not answered after hours or answered after hours by a recorded message instructing enrollees to call back during office hours or to go to the emergency department for care is not acceptable. It is not acceptable to refer enrollees to the PMP's home telephone if there is not a system in place as outlined above to respond to calls. Systems designed to refer all requests to go physically to the Emergency Room are not acceptable. PMPs are encouraged to refer patients with urgent medical problems to an urgent care center. Failure to comply with the 24/7 coverage requirements may result in a hold being placed on the PMP's panel (see section 39.3.7 for information on Panel Holds).

39.3.4 Standards of Appointment Availability and Office Wait Times

The PMP must conform to the following standards for appointment availability:

- Emergency care – immediately upon presentation or notification
- Urgent care – within 24 hours of presentation or notification
- Routine sick care – within 3 days of presentation or notification
- Routine well care – within 90 days of presentation or notification (15 days if pregnant)

The PMP must conform to the following standards for office wait times:

- Walk-ins – within two hours or schedule an appointment within the standards of appointment availability
- Scheduled appointment – within one hour
- Life-threatening emergency – must be managed immediately

If these standards cannot be met due to extenuating circumstances, then the patient should be informed within a reasonable amount of time and given an opportunity to reschedule the appointment.

39.3.5 Patient 1st Medical Records Guidelines

Medical records should reflect the quality of care received by the client. However, many times medical records documentation for the level of care provided varies from provider to provider. Therefore, in order to promote quality and continuity of care, a guideline for medical record keeping has been established by the Patient 1st program. All Patient 1st PMPs must

implement the following guidelines as the standards for medical record keeping.

1. Each page, or electronic file in the record, contains the patient's name or patient's Medicaid identification number.
2. All entries are dated.
3. All entries are identified as to the author.
4. The record is legible to someone other than the writer, including the author.
5. Medication allergies and adverse reactions are prominently noted and easily identifiable as well as the absence of allergies.
6. Personal and biographical data is recorded and includes age, sex, address, employer, home and work telephone numbers, and marital status.
7. Past medical history is easily identified including serious accidents, operations, and illnesses. For children, past medical history relates to prenatal care and birth.
8. There is a completed immunization record. For pediatric patients (age 12 and under) there is a complete record with dates of immunization administration.
9. Diagnostic information, medication, medical conditions, significant illnesses, and health maintenance concerns are recorded in the medical record.
10. Notation concerning smoking, alcohol, and other substance abuse is present.
11. Notes from consultations are in the record. Consultation, lab and X-ray reports filed in the chart have the ordering provider's initials or other documentation signifying review. Consultation and significantly abnormal lab and imaging results have an explicit notation in the record of the follow-up plans.
12. Emergency care is documented in the record.
13. Discharge summaries are included as part of the medical record for hospital admissions.
14. Documentation of individual encounters that provide adequate evidence of appropriate history, physical examination, diagnosis, diagnostic test, therapies, and other prescribed regimen, follow-up care, referrals and results thereof, and all other aspects of patient care, including ancillary services.

39.3.6 Recipient Education

Recipient education will be an integral part of the program to help the recipients understand the Patient 1st Program system and their responsibilities under such a system. The Agency has recently outlined in the Patient Handbook the recipient's rights and duties as being part of the Patient 1st Program. All educational materials have stressed the importance of contacting the PMP before receiving services, which services do not require a PMP referral, and most importantly, the Recipient Call Center (1-800-362-1504) number to call anytime there is a question.

In addition, as the coordinator of care, it is important for PMPs to be actively involved in patient education. Patient 1st PMPs are strongly encouraged to contact all new enrollees by telephone or in writing. New enrollees are identified in the monthly PMP Enrollment Roster.

Providers should address the following subjects with each new enrollee:

- The PMPs requirement to provide medical advice and care 24 hours per day, 7 days per week and the preferred method for contacting the PMP.
- The requirement that the enrollee contact the PMP for a referral before going to any other doctor.
- The requirement that the enrollee must contact the PMP before going to the emergency department unless the enrollee feels that his/her life or health is in immediate danger.
- The importance of regular preventive care visits such as Well Child Check-ups (EPSDT) screenings for children, immunizations, check-ups, mammography, cholesterol screenings, adult health assessments, and diabetic screenings.
- The availability of additional information for enrollees from the Agency.

39.3.7 Agreement Violation Provisions

Failure to meet the terms outlined in the Patient 1st provider agreement may result in the imposition of one or more of the following sanctions:

- A limit may be imposed on member enrollment.
- All or part of the monthly case management fee may be withheld
- The PMP may be referred to Program Integrity (PI) or Quality Assurance (QA) Unit for investigation of potential fraud or for quality of care issues.
- The PMP may be referred to the Board of Medical Examiners.
- The PMP may be terminated from the Patient 1st program.

Medicaid makes the determination to initiate sanctions against the PMP and may impose one or more sanctions simultaneously based on the severity of the contract violation. The Medicaid Legal Division may initiate a sanction immediately if it is determined that the health or welfare of an enrollee is endangered or Medicaid may initiate a sanction to begin within a specific period of time. Failure to impose a sanction for a contract violation does not prohibit Medicaid from exercising its right to do so for subsequent contract violations.

Panel Holds

A panel hold is a temporary hold on the PMP's panel. The following are common reasons why a PMP's panel may be placed on hold:

- Adverse licensure action by the Board of Medical Examiners (BME)
- Sanctions by Alabama Medicaid (i.e. referrals to Program Integrity)

- Significant complaint(s) about a PMP; must be approved by the Medical Director
- Disenrollment due to PMP abandonment (PMP left town without notifying Medicaid)
- Upon PMP request
- Failure to comply with terms of Patient 1st contract (i.e. 24/7 voice coverage, hospital coverage)

Panel holds:

- Do not prevent the PMP from seeing his/her assigned patients
- Do not affect payments to the PMP (including capitation)
- Do prevent the PMP's office staff from making any changes to the panel

Any changes to the panel must be done manually by Medicaid if there is a panel hold. Contact the Patient 1st program if changes are needed.

When Patient 1st is alerted of any extreme issues (i.e. active investigation by Medicaid or the BME) regarding a PMP, the Patient 1st staff will contact the PMP's office by phone and/or email to discuss the issue. At that time, if the issue is resolved no further action will be taken.

If the issue is not resolved via phone or email contact, a certified letter will be mailed to the PMP identifying the outstanding issue(s) and the consequences for failure to respond. The PMP will be given **14 business days upon receipt of the letter** to respond. Failure to respond to the certified letter in the timeframe given may result in one of the following:

- A panel hold may be placed on the PMP's panel
- Patients may be reassigned to other PMPs
- PMP may be dismissed from the Patient 1st Program

The PMP will be notified by an additional certified letter once an action has been made on his/her panel.

39.3.8 Agreement Violation Appeals

The PMP is notified by certified mail of the sanction(s) and the right to appeal the sanction. Medicaid must receive the PMP's request for a formal evidentiary hearing by the Medicaid Legal Division no later than 15 calendar days from the receipt of the sanction notice. The hearing provides an opportunity for all side to be heard in an effort to resolve the issue. The sanctioned party may represent himself/herself or may enlist the services of an attorney or designate a representative. The findings are documented by the Legal Division and presented to the Commissioner who makes the final determination to uphold or rescind the sanction. The PMP is notified by certified mail of the Commissioner's decision.

PMPs that are terminated from the Patient 1st program – or voluntarily withdraw to avoid a sanction – are not eligible to reapply for a minimum of one year with a maximum time period to be determined by the Agency. The decision is predicated on the extent or severity of the contract violation, necessitating the termination.

39.4 Monthly Case Management Fee

The PMP is paid a case management fee per month for each recipient the PMP has enrolled, as of the first day of each month. However, Federally Qualified Health Centers, Independent Rural Health Clinics and Provider Based Rural Health Clinics do not qualify for the case management fee.

There is no limit on the accumulation of case management fees; however, the fees paid are contingent upon the fee components referenced in 39.4.1. The case management fee will generally be paid on the first checkwrite of the month. The case management fee will be automatically generated based on Medicaid enrollment reports. Therefore, the PMP is not required to file a claim for the case management fee. All other services provided are reimbursed by the current fee-for-service method.

39.4.1 Case Management Fee Components

PMP's will receive a case management fee that reflects the contractual requirements to which the PMP has agreed. The components of the fee are delineated below. Details on the components are provided so that the PMP can determine whether the component can be met. This information will be entered based on the providers Medicaid enrollment and the Patient 1st application submitted.

Components	Case Management Fee
PMP participating in the Patient 1st Program	$.50 Per Member Per Month (PMPM)
PMP contracting with Health Home	$8.00 Per Member Per Month (PMPM)
FQHC & RHC	Considered to be included in the PPS payment.

39.5 Monthly PMP Enrollment Roster

The following report is available to PMPs to help identify and manage patients on their panel. Effective March 1, 2010, Medicaid will discontinue printing and mailing this report. The report can be accessed through Medicaid's Interactive Website.

The first of each month, the PMP can obtain a listing of pending enrollees (new patients) that the Agency has assigned for a future date (approximately 30 days), all continuing enrollees that are the responsibility of the PMP for the month and those enrollees that have been terminated from the provider's panel. The listing will include the recipient's demographic information, Medicaid number, assignment effective/end date, aid category, reason assigned to the PMP, county code and review date. The enrollee status will be noted at the top of each page as pending, continuing or terminated.

Pending Enrollees (New) – enrollees that are new to your panel. A reason code will be listed on the report indicating the start reason or why the enrollee was assigned to the panel

- Continuing Enrollees – enrollees that have been previously assigned and continue to be assigned to the PMP

- Terminated Enrollees (Deleted) – enrollees that have been deleted from the PMP's panel. A reason code will be listed on the report indicating the stop reason or why the enrollee was deleted from the panel

Below is the code legend that will be listed on the last sheet of the enrollment roster explaining the enrollees' start/stop reason and their aid category.

Code Legends

Aid Category codes:

21 Blind-SSI-Full Medicaid coverage
30 MLIF-Child-Full Medicaid coverage
32 MLIF-Child with No Money-Full Medicaid coverage
34 MLIF- Adult-full Medicaid coverage
36 MLIF-Adult-No Money-Full Medicaid coverage
38 MLIF-Adult-No Money-Full Medicaid coverage
39 MLIF-Child-No Money-Full Medicaid coverage
3J Transitional Medicaid-Child-Full Medicaid coverage
41 Disabled-SSI-Full Medicaid coverage
46 Disabled-D.O. No Money-Full Medicaid coverage
51 SOBRA Child-No Money (<100%FPL)-Full Medicaid coverage
52 SOBRA Child-No Money (<133%FPL)-Full Medicaid coverage
54 SOBRA Child (Newborn)-No Money-Full Medicaid coverage
55 SOBRA Child-Pregnant-No Money-Full Medicaid coverage
81 Foster Care Kids (State Opt)-DHR-Full Medicaid coverage
5E CHIP Kids- Full Medicaid coverage
3A Breast & Cervical Cancer with Full Medicaid coverage

Start/Stop Reason codes:

01 Not happy about the PMP assignment
06 PMP location not convenient
07 Change form submitted/no reason given
08 PMP requested recipient via letter
FN Special Handling
HI Historical
NE Newborn
PP Past PMP
PR Proximity
SI Sibling (Case)
AK ALL Kids

In addition, a cover sheet will be included that provides information about the PMPs panel and will list the following:

- Region – indicates the provider is enrolled in the Statewide Patient 1st program
- Distance – distance (radius) the provider will accept recipients. Default is set at 75 miles
- Current Panel Size – the number of patients currently assigned to the PMP
- Future Panel Size – the number of patients assigned once pending enrollees become effective
- Maximum Panel Size – the maximum caseload that can be assigned

- Minimum/Maximum Age – the age range of enrollees the PMP specified he/she wanted on their panel
- Effective/End Date – provider's effective and end dates as enrolled in the Patient 1st program
- Special Conditions – lists case management fee components the provider is participating in and is being paid a case management fee
- Case Management Fee – the case management fee amount paid to the provider based on the case management components he/she agreed to participate in.

It is the PMP's responsibility to review this roster every month and report any errors to Medicaid. PMP's must continue to coordinate care for any enrollees who are linked to the practice, even if a change has been requested or an error has been reported until the change or error has been resolved and reported correctly.

The PMP should use this list to gauge caseloads, ensure service can be provided to all enrollees, and to determine if any patients have previously been dismissed. Pending recipients on the list are not final, as the patient will have until the 15th of the month preceding the enrollment date to change.

NOTE:

This list is not a substitute for eligibility verification. All providers should always verify Medicaid eligibility prior to rendering services.

39.6 Eligible Recipients

The Agency is responsible for recipient enrollment in Managed Care programs. Patient 1st is mandatory for most Medicaid recipients. Medicaid eligibles that must participate in **Patient 1st** are those for whom eligibility has been determined as listed below. Eligibility categories include:

- SOBRA eligible children
- MLIF and MLIF related
- Refugees
- Blind
- Disabled
- Aged
- Infants of SSI mothers

Medicaid recipients in the above categories of Medicaid eligibility are **excluded from participation in Patient 1st in the following circumstances.**

NOTE:

Those categories with an asterisk are not automatically removed from the program. These individuals must be reported to Patient 1st for removal from the program. Removal from Patient 1st does not affect their normal Medicaid benefits.

- Medicaid eligibility is retroactive only;
- Recipient is enrolled in another managed care program in which access to primary care physician is limited (i.e., HMO);*
- Recipient resides in a residential or institutional facility such as a nursing home or ICF/MR or a group or foster home or DYS (Department of Youth Services);*
- Recipients with dual eligibility (Medicare and Medicaid); and
- Recipients who have been determined to be Medically Exempt from the Patient 1st Program, including:*
- Terminal illness – the enrollee has a life expectancy of six months or less or is currently a hospice patient,
- Continuity of Care issues (*Note:* A temporary exemption may be granted to allow a Patient 1st enrollee to continue to see a non-participating physician while the physician is in the process of applying for participation in Patient 1st).
- Diagnosis/Other – an enrollee may be granted an exemption if there is a specific diagnosis or other reason why the enrollee would not benefit from coordinated care through a PMP.
- SOBRA Pregnant Women- full Medicaid benefits will be received throughout the pregnancy and post-partum whether the services are pregnancy related or not. A PMP referral is NOT required to receive non-pregnancy related services. (Claims that are pregnancy related will require a pregnancy related diagnosis code).

Patient 1st Medical Exemption Request form must be completed by the enrollee's physician and mailed to the Patient 1st Program, Alabama Medicaid Agency, 501 Dexter Avenue, Montgomery, Alabama 36103 or faxed to (334) 353-3856. A copy of the form is included in Appendix E and on the Agency's website at www.medicaid.alabama.gov.

Recipients are removed from **Patient 1st** participation if they are changed to an excluded aid category, or if they lose eligibility or change place of residence. Dependent upon when a person becomes Medicaid eligible, they may not yet be enrolled in **Patient 1st.**

If you have a patient who is enrolled in **Patient 1st** who should not be enrolled, please contact the Recipient Call Center at 1(800) 362-1504.

Eligibility verification indicates enrollment status and assigned PMP name and telephone number.

39.7 Recipient Enrollment/Assignment

39.7.1 Enrollment

To facilitate enrollment into the Patient 1st Program, recipients required to participate are assigned a PMP. Recipients have the ability to change PMP providers on a monthly basis. Dependent upon when a person became Medicaid eligible, they may not yet be enrolled in Patient 1st. **Always verify eligibility**.

Recipients who are added to the eligibility file (refer to 39.7.2 below for information regarding newborns) are notified of their Patient 1st assignment approximately 30 days prior to the effective date of the assignment. The purpose of the 30-day lead time is to allow recipients to change providers prior to actual PMP assignment. Providers will be notified at the same time as recipients of assignments.

The computer assignment algorithm is as follows:

- **Newborn** Will check for the person to be on the newborn list sent from the state.
- **Past PMP on file and Sibling cases**- will be checked. If caseload and age criteria can be met, then assignment will be made to that PMP. Additionally, sibling cases will be checked to see if a sibling is in the program based on payee number. If there is no payee number, then this step cannot be considered. Siblings already enrolled or those in the same batch will be considered. If two siblings are enrolled and assigned to different PMPs, then the new siblings will be assigned to the PMP of the youngest sibling.
- **Historical Claims history** will be considered for 6 months.
- **Proximity assignment** based on PMPs distance from the recipient's zip code as long as caseload is available and age criteria can be met.

39.7.2 Newborns

Mothers of infants who will be required to participate in the program have the opportunity to select the provider they want for their child's PMP prior to assignment by the Agency. This is accomplished through the completion and submission of a Newborn Assignment Form. These forms are available through a variety of sources including, but not limited to, the physician's office, the Maternity Care Program Care Coordinator, and the hospital. The form must be completed and submitted prior to the Agency's assignment of the infant. Newborn assignments may be faxed to DXC at (334) 215-4140. In order for the request to be granted, the PMP must have available caseload for the recipient's area.

39.7.3 Eligibility Verification

It is the provider's responsibility to verify that a person is eligible for Medicaid at the time of service. There are three sources available for obtaining recipient information:

- The Provider Electronic Solution (PES) is a point of service device or PC based software system, which accesses recipient information.
- The Automated Voice Response System may be accessed by dialing 1 (800) 727-7848 using a true touch-tone telephone. This is an automated telephone system available approximately 24 hours a day, 7 days a week unless down for maintenance.
- The Provider Assistance Center at DXC can be reached at 1 (800) 688-7989 from 8:00 am – 5:00 pm, Monday through Friday.

The verification will give contact information for the recipient's assigned PMP.

39.7.4 Recipient Changes of Primary Medical Providers

Enrollees may request to change their PMP at any time. DXC is responsible for processing an enrollee's change request. Enrollees can change PMPs by calling the Recipient Call Center (RCC) at: 1-800-362-1504, or by mailing to: 301 Technacenter Drive, Montgomery, AL 36117 OR P. O. Box 241685, Montgomery, AL 36124 https://www.medicaid.alabamaservices.org/ALPortal/. The Agency monitors the reasons for change as part of the program compliance protocol.

Enrollments and disenrollments to effect a change in PMP are effective the first of the month, following the date of the change if the request for change is received by the Agency by the 15th of the month. If requests for changes are received after the 15th, the change is effective the 1st of the following full calendar month.

NOTE:

If changes are not received by the 15th of the month, assurances for an effective date for the first of the following month cannot be given. This will allow a 5 day processing timeframe.

Please see Appendix E of the Medicaid Provider Manual for a copy of the PMP change form that can be utilized by the recipient. Patient requested changes are confirmed by a mailing prior to the 1st of the month in which the change is effective.

39.7.5 PMP Dismissal of Recipient

Medicaid requires PMPs to use the Medicaid Interactive Web Portal to dismiss recipients from their panels. A PMP may remove a recipient from his panel due to good cause. *According to the guidelines listed in the State Plan authority granted under section 1932(a)(1)(A) of the Social Security Act which allows the operation of the Patient 1st program, good cause is defined as:

- Behavior on the part of the recipient which is disruptive, unruly, abusive or uncooperative to the extent that the ability of the provider to provide services to the recipient or other affected recipients is seriously impaired,
- Persistent refusal of a recipient to follow a reasonable, prescribed course of treatment; or
- Fraudulent use of the Medicaid card.

Additionally, a Patient 1st enrollee may be disenrolled for nonpayment of co-payments or an outstanding balance if this is a standard operating procedure for the practice, and it is applicable to all patients regardless of payer source, and prior written notice has been provided to the enrollee.

However, a recipient may not be charged or billed a cancelled or missed appointment ("no-show") fee. Refer to Chapter 6 of the Administrative Code for further information.

The PMP is responsible for sending a letter of dismissal to the recipient. PMPs are required to notify the recipient 30 days prior to dismissal. The dismissal letter should be addressed to the patient and signed by the PMP.

Recipients will be given the opportunity to change the selected PMP before the active assignment date. **The original PMP must continue to provide services or make referrals for services to the recipient until such time the reassignment is complete**. All reassignments will be made effective the 1st of a month.

PMP Disenrollment

Patient 1st enrollees will be assigned to a different PMP if a PMP dies, moves out of the service area, or loses Medicaid and/or **Patient 1st** provider status. Such reassignment is usually accomplished by automated means. Medicaid sends a notice to the affected recipients, telling them of the reassignment, and the reason for the reassignment. They may then select another PMP if the reassignment is not satisfactory.

PMP Leaves Billing Practice

If a PMP leaves a group billing practice, the patients will be reassigned to the remaining practitioners within the billing practice upon request.

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

PMP Site Change

If it is a situation of a PMP leaving one site to open another site, the patients will be reassigned to the remaining practitioner.

PMP Closing a Site

If it is a situation of a PMP maintaining two locations within the same geographical area, then the patients from the closed site will be reassigned to the site remaining open. This will apply if the PMP is maintaining a group or clinic site or private practice site.

39.7.6 Referral Form

All referrals must be documented on the *Alabama Medicaid Agency Referral Form (Form 362).* Hard copy referrals require the printed, typed, or stamped name of the primary care physician with an original signature of the physician or designee. This means that a signature signed by the physician's designee, must be a complete signature, **not** initials.

(Alabama Medicaid Administrative Code Rule No. 560-X-1-.18 (2) (d), Provider/Recipient Signature Requirements, Referral Forms.

Referral authorization from the PMP must be given prior to patient treatment. If given verbally, ** a written referral form, from the PMP to the consultant, must follow within 72-hours of the verbal authorization.

The form can be obtained by accessing Medicaid's website.

Referral Process

Coordination of care is an important component of Patient 1st. PMPs are contractually required to either provide services or authorize another provider to treat the enrollee while adhering to the referral process. This applies even when an enrollee has failed to establish a medical record with the PMP. The patient does not have to be seen by the PMP prior to a referral being given.

PMPs may make referrals to any practitioner that can best meet the patient's needs. However, every effort should be made to refer patients to Medicaid enrolled physicians that are geographically accessible to help facilitate the reimbursement process.

In some cases, the PMP may choose to authorize a service retroactively. All referrals, including services authorized retroactively, are at the discretion of the PMP. Some services do not require referral; refer to Section 39.10 of this Chapter for more information.

In addition to Patient 1st PMP referral, prior approval (PA) - may be required to verify medical necessity before rendering some services. PA is for medical approval only. Obtaining PA does not guarantee payment or ensure recipient eligibility on the date of service.

Refer to Chapter 4, Prior Approval of the Medicaid Provider Manual for additional information about services requiring PA.

39.7.7 Comprehensiveness / Duration of Referral

The comprehensiveness and duration of the referral is determined by the PMP and the other provider. The referral may cover one visit or it may cover multiple visits as long as those visits are part of a plan of care and are medically necessary. A new approval must be provided if the diagnosis, plan of care or treatment changes.

If the consulting physician decides that the recipient must be treated by another consulting physician (or another provider who is not the PMP), the first consulting physician must contact the PMP for approval and authorization to further refer the patient, unless such approval has already been **indicated on the referral form.** The second provider should then use the PMP's approval code when billing. This same procedure should be followed for **any** successive referrals.

The Physician's NPI number on the Patient 1st Referral Form must be the NPI of the referring physician and not the NPI of the group. Providing the group's NPI number instead of the individual PMP's NPI number will cause the claim to deny.

If the Patient 1st PMP is with a Clinic/Group, then the referral number should be the individual PMP's NPI number and not the Clinic's NPI.

39.7.8 EPSDT Screening Referrals

It is not necessary to redo EPSDT screening referrals on the Patient 1st/EPSDT Referral form. If the original screener is not the PMP, then the PMP must either sign on the original Patient 1st EPSDT referral form (anywhere is acceptable) or issue a written **Patient 1st** referral. Referrals

can be for duration of up to 12 months for EPSDT referred services. Referrals from a previous PMP may be honored for a 6 month time frame Please refer to the Appendix A of the Medicaid Provider Manual. In addition, screenings performed prior to enrollment as Patient 1st are acceptable as long the PMP concurs with the findings and treatment plan.

39.7.9 Providers within a Billing Group

Physicians within the same billing group/clinic and are enrolled in Patient 1st with a group/clinic number are not required to have referrals among the group/clinic physicians. If a group/clinic physician is covering for another PMP and a patient requires a referral to a provider outside the group/clinic, then the authorization number of the covering PMP must be provided to the referred provider and noted in the chart and documented on the referral form.

If the rendering provider is not a PMP, but in the common group- no paper referral will be required but the referring providers NPI/Medicaid ID must be on the claim in order for it to pay.

39.7.10 Referral for Coverage of Non-Group/Clinic Non-Clinic Physicians

When a physician is providing coverage for a PMP (outside of a formal clinic/practice) and services are rendered to an enrollee, the covering physician must provide the PMP with documentation as to the nature of the services rendered and any follow-up required for placement in the patient's medical record. The PMP must provide the covering physician with a referral authorizing such coverage in order to facilitate reimbursement.

39.7.11 Referral for a Second Opinion

Patient 1st PMPs are required to refer an enrollee for a second opinion at the request of the enrollee.

39.7.12 Referral for Non-Established Patients

The Agency understands that it may be the policy of a PMP not to issue a referral unless the patient is established. We can appreciate the need to know a patient in order to appropriately manage his or her care. However through **Patient 1st,** new patients are continually added—patients which the PMP may not have an established relationship. If a patient who is a new patient or one who has not consulted with the PMP requests a legitimate urgent referral, we suggest that you issue the referral and use this opportunity to schedule a follow-up visit. If the patient refuses to follow-up with a visit to your office at that time, it would be appropriate to refuse further referrals or pursue the option of dismissing the patient if behavior is deemed to be of a non-compliant nature. See “PMP Dismissal of Recipient”.

Keep in mind that many of these patients have changed their PMP assignment to the physician to whom they are currently seeing or have been seeing in the past. For one month, the patient may be assigned to you as a PMP. If a referral is necessary during this one month, then it can be documented as a billing referral only.

NOTE:

PMP referral grants access only to service, it does not supersede benefit limits and/or other authorization processes. Please refer to the Appendix E for Patient 1st services that require a referral and services that **do not** require a referral.

39.7.13 *Special Authorizations*

There are situations in which a PMP may be requested to authorize Medicaid services for a recipient who no longer lives in the service area, who changes eligibility categories and is no longer in a category covered by **Patient 1st** , or who has changed PMPs. Examples for the most common of these situations are given below:

Example 1

The recipient moves outside the PMP's distance criteria and selects another PMP. If the recipient needs medical care and his/her address has not been changed (perhaps in the middle of the month), the provider must contact the PMP for authorization of services.

Example 2

A child is removed from an MLIF case because he/she is now in foster care and eligible for Medicaid under the foster care program. If the child needs medical care during the period that his/her **Patient 1st** still is in effect (usually in the middle of the month), the provider must contact the PMP for authorization of services in the same manner as described above.

39.7.14 Referral for Billing Purposes Only

A PMP may approve a referral for billing purposes only. Such a referral should be documented "For Billing Purposes Only" on the standard billing referral form in the space provided under REFERRAL VALID FOR. The billing procedure for this type of referral is the same as all other referral types.

39.7.15 Billing for Referred Services

If a Patient 1st enrollee goes to any other Medicaid provider for non-emergency services other than those exempted in Appendix E, without the referral from the assigned PMP for Patient 1st services, the provider should refer the enrollee back to or contact the assigned PMP. If the assigned PMP authorizes the services at that time, he/she can give the provider his/her NPI for entry on the claim form and Medicaid will pay the claim if the enrollee is eligible and has benefits available. If the Medicaid recipient insists upon receiving the unauthorized service, he/she should be informed that Medicaid will not pay the claim and that the recipient will be responsible for payment of services rendered.

A pharmacist does not have to contact the PMP prior to filling a prescription written by another Medicaid provider, but must enter on the claim form the license number of the prescribing physician.

For complete billing instructions, refer to Chapter 5 of the Medicaid Provider Billing Manual.

39.7.16 Authorization Number

Access to services is authorized through use of the PMP's 10-digit NPI. To facilitate the process, and lessen the administrative burden for the physician, the following procedures are used when processing claims:

Step One (Billing Provider)

- The **PMP** NPI on the claim is compared against the **PMP** NPI to whom the recipient is assigned. If they match, the claim continues through Medicaid edits.
- The group number of the provider on the claim is compared against the group number on the PMP file. Groups are assigned a group number. If they match, the claim continues through Medicaid edits. 'Informal' groups are not considered to be a group as they cannot be identified systematically.

Step Two (Referring Provider)

- The referring **PMP's** NPI indicated on the claim is compared against the NPI to whom the recipient is assigned. If they match, the claim continues through Medicaid edits.
- The referring **PMP**'s NPI number on the claim is matched against the group number of the individual NPI number on the PMP file. If they match, the claim continues through Medicaid edits.
- If the claim is for **Patient 1st** coordinated services and steps one and two do not apply, the claim will be denied with an **EOB** Code of **1820**. An **1820** denial code means 'Recipient enrolled in the **Patient 1st** Program, services require referral from PMP'.

When making Patient 1st referrals, the PMP must provide his/her10-digit NPI to be used by the consulting provider. All PMP referrals must be in writing. The PMP may make the referral verbally, but must follow with a written referral to the requesting physician within a 72-hour period of the verbal authorization.

39.7.17 Override Requests

In extenuating circumstances, on a case-by-case basis, and after thorough review, Medicaid may determine that a referral override may be prudent in some situations. Providers must request an override using the **Patient 1st Override Request form** to obtain payment. A copy of the **Patient 1st Override Request form** is in Appendix E of the Medicaid Provider Manual. An Override Request Form and a clean Red Drop Ink claim form* must be submitted to the Patient 1st Program by mail within 90 days of the date of service. Requests will be evaluated within 60 days of receipt. Overrides will not be approved for well visits.

NOTE:

All efforts to obtain a referral from the PMP should be exhausted before an Override Request is submitted. *Refer to Chapter 5, “Filing Claims” of the Medicaid provider manual.

39.8 Complaint / Grievance Process

39.8.1 Filing a Complaint or Grievance

Enrollees can file complaints or grievances through the 1(800) 362-1504 Recipient Call Center or in writing by submitting a Patient 1st Complaint form to the address indicated on the form (a copy of the form is available in Appendix E or from the Agency). Providers can file complaints or grievances through the Medicaid Agency at (334) 242-5010 or in writing to: P.O. Box 5624 Montgomery, AL 36103-5624. Enrollees or Providers may file complaints or grievances about their assigned provider or other aspects of the **Patient 1st** Program system. Medicaid’s Managed Care QA Program will thoroughly investigate each complaint or grievance and report the results of its findings back to the enrollee or provider. When appropriate, the enrollee's assigned provider will be notified to document the complaint and obtain necessary correction of problems noted. In especially acute situations, Medicaid may use the special authorization system or various procedure exception systems to resolve the grievance. The enrollee may appeal the action or may request a formal Medicaid hearing. Complaints by other providers or reports by informants are investigated similarly to grievances.

Grievance Log

Medicaid will maintain a log of the grievances received and their disposition. Complaints/Grievances will be "categorized” as a tool by which to assess program impact. Complaints/Grievances usually fall into one of the following five categories:

1. Contract violations/program policy
2. Professional conduct – general
3. Professional conduct – physical, sexual or substance abuse
4. Quality of care
5. Program fraud/abuse

39.9 Detail on Select Services

39.9.1 Benefits

Patient 1st enrollees have the same range scope, amount of services and co-payments as other Medicaid recipients. There are some services that are excluded from the **Patient 1st** program and do not require authorization by the PMP. These are obtained through the same procedure as used by other Medicaid recipients outside the Patient 1st program. It is anticipated;

however, that the enrollee will look to the PMP for advice and/or coordination of these services. **Patient 1st** enrollees should be offered the same level of service coordination for non-authorized services as would other patient populations.

The **Patient 1st** Program does not extend or supersede any existing program benefit or program requirement. A matrix of what services **do** and **do not** require referral follows.

PATIENT 1ST SERVICES NOT REQUIRING PMP REFERRAL

Service	Claim Type	System Identification
Allergen/Immunotherapy	M	Procedure Codes 95115-95199 (Administration of allergy injections)
Ambulance	M	Ambulance-Ground and Air
CRNA	M	Certified Registered Nurse Anesthetist
Certified Emergency	M O	Any service rendered by a provider resulting from a documented certified emergency (utilize claim block 24- C with an "E" indicator on the CMS -1500 Claim Form; utilize claim block 73 with an "E" indicator on the UB-04 Claim Form.)
Dental	M D O	Dentists & Federally Qualified Health Centers (Claim Type D only), Clinics- Children's Dental/Orthodontia and Orthodontists, Oral, Maxillofacial Surgeons Procedure Codes: D8080 (Comprehensive orthodontia treatment of adolescent dentition), D8680 (Orthodontic retention-removal of appliances, construction/ placement of retainers), D9430 (Office visit for obs services during regular hours) Outpatient facility procedure codes D9420. Note: OP facilities do not require a referral for **DENTAL** procedures.
Dialysis	O	Dialysis Centers
EEG/EKG Related Services	M O	Procedure Codes: 93000-93278 (Routine ECG w/at least 12 leads w/interpretation & report), 95805-95827 (EEG related services)
Early Intervention Services	M	Provider type 63
End Stage Renal Disease	M	Nephrologists Diagnosis Code: 585.6 ICD-9 or N18.6 ICD-10 (End Stage Renal Disease)
EPSDT Developmental Diagnostic Assessment	M	Procedure Codes: 96110 & 96111 (EPSDT Developmental Assessment) **NOTE: Other EPSDT requires referral**
Eye Exams, non-medical	M	Optometrists **Routine Eye Care/Vision exam** Procedure Codes: 92002-92015, 92313 (Corneoscleral lens) **NOTE: Ophthalmological services require referral**
Eyeglass & Other Lens Fittings	M	Procedure Codes: 92340-92355 (Fitting of spectacles), 92310-92312 (Prescription/fitting for contact lens-medical supervision of adaptation)
Eyeglasses/Lens	M	Procedure Codes: V0100-V2799 (CMS Assignment of Vision Services), V2020 (Standard Eyeglasses, Frames), V2025 (Eyeglasses, Special Order Frames, 92315-92317 (Corneal Lens/Corneosclera Lens) 92326 (Replacement of Lens), 92370 (Repair of spectacles)
Factor 8	ANY	Procedure Codes: J7197, J7198, J7199(Anti-Inhibitor Coagulant Complex), J7193, J7194, J7195(Factor IX Complex-Per IU)

M=Medical (CMS 1500) I=Inpatient O=Outpatient D=Dental

PATIENT 1ST SERVICES NOT REQUIRING PMP REFERRAL

Service	Claim Type	System Identification
• Medical • Outpatient	M 0	**Medical Outpatient:** Family Planning Indicator (Y) – Procedure Codes: 58300-58301 (Insert intrauterine device), 58600 (Ligat/Trans of fallopian tubes), 58605 (Ligat/Trans of fallopian tubes), 58611 (Ligat/Trans of fallopian tubes), 58615 (Ligat/Trans of fallopian tubes), 50610 (Initial visit), Birth control pills, Adolescent pregnancy prevention education, Hormonal IUD, 11976-11981 (Removal, implantable contraceptive capsules/Insertion, non-biodegradable drug delivery implant, 55250 (Vasectomy), 55450 (Ligation: vas deferens), 58670-58671 (Laproscopy), 57170 (Diaphragm fitting), Depo Provera; Diagnosis Codes: V25-V259 for ICD-9 or Z30011–Z309 for ICD-10 (Contraceptive Management)
Gynecology/Obstetrics	M	OB/GYN-Any service performed by this specialty is exempt from referral requirement. Note: **OP facility** fees for OB/GYN services require a PMP referral unless for Family Planning or Maternity Services as defined herein.
HCBS Services	M	Providers of HCBS waivered services i.e. Elderly & Disabled Waiver-ED, Homebound Waiver-EC, and MR/DD Waiver-EE)
Hearing Aids	M	Hearing Aid Dealers (EPSDT only)
Hospice	O	Hospice
Immunizations	M O	Immunizations (see section 39.9.4 for more details on immunizations)
Infant Birth Diagnosis	ANY	Diagnosis Codes: V30-V391 for ICD-9 or Z38.00-Z38.8 for ICD-10 (Single Liveborn)
Inpatient Consults	M	Procedure Codes: 99251-99263 (Initial inpatient consult), 99360 (Physician Standby), 99436 (Attendance at delivery)
Inpatient Hospital • General • Psychiatric • Physician Hospital Visit	I	Hospital

M=Medical (CMS 1500) I=Inpatient O=Outpatient D=Dental

PATIENT 1ST SERVICES NOT REQUIRING PMP REFERRAL

Service	Claim Type	System Identification
Laboratory	M	Independent Labs & Hospitals-(Claim Type OP) - Outpatient Hospital Lab Services-Procedure codes: 36415 (Routine Venipuncture), 36416 (capillary blood specimen), 80048-89399 (Pathology & Lab Organ or Disease Panels); Outpatient Hospital Chemotherapy-procedure codes: 96400-96549 (Chemotherapy Administration)
Long Term Care (LTC) • Intermediate Care Facility-Mentally Retarded (ICF-MR) • Nursing Home	I	Nursing Homes & ICF-MR Facilities
Maternity Care Program	M	Maternity Care Program-Primary Caregiver
Maternity Services	M O	Diagnosis Codes: 640-67694 for ICD-9 or O20.0-O9A.53 for ICD-10 (Pregnancy-related)
Mental Health Services	M	Mental Health Services **NOTE:** Includes Community Mental Health Centers and other providers with same provider type. PMP notification is required for services rendered.
Newborn Care	M	Procedure Codes: 54150 (Circumcision/clamp), 54160 (Circumcision/surgical), 99440 (Newborn resuscitation), 99431-99436 (History/exam of newborn), 99360 (Physician Standby)
Optometrist/Optician	M	Optometrist/Optician **Routine Eye Care/Vision exam (Glasses/Lens do not require PMP referral)**
Physicians	M	Anesthesiologists, Oral & Maxillofacial Surgeons, Pathologists, Radiologists/Diagnostic, Nuclear Medicine Physicians ****All other physicians require referral in any office or outpatient setting.**
Pregnancy-Related Services	M O I	Diagnosis Codes: 640-67699 for ICD-9 or O20.0-O9A.53 for ICD-10 (Pregnancy-related), V22-V242 for ICD-9 or O09.00-O09.93, O36.80X0-O36.80X9, Z33.1-Z33.1, Z34.00-Z34.03, Z34.80-Z34.83, Z34.90-Z34.93, and Z39.0-Z39.2 for ICD-10 (Normal pregnancy-routine postpartum f/u), V27-V289 for ICD-9 and Z36-Z37.9 for ICD-10 (Outcome of delivery)
Preventive Education	M	County Health Department, Preventive Ed
Professional Component	M	Modifier 26; Procedure Codes: 93010 (Interpretation/Report of Cardiography), 93237 (Physician review/report), 93300-93399 (Echo)
Radiology	M	Independent Radiologists & Hospitals (Claim Type OP) Outpatient Hospital Radiology-procedure codes: 70010-79999 (Diagnostic Radiology)

M=Medical (CMS 1500) I=Inpatient O=Outpatient D=Dental

PATIENT 1ST SERVICES REQUIRING PMP REFERRAL

Service	Claim Type	System Identification
Ambulatory Surgical Center	O	Lithotripsy other than physicians and centers **NOTE:** Includes Ambulatory Surgical Centers and Lithotripsy
Anesthesia	M	Physicians **EXCEPTION:** Anesthesiologists-Consults performed in the inpatient hospital setting do not require a Patient 1st referral. Consults performed in a setting other than inpatient hospital require a Patient 1st referral.
Audiologists' Services	M	Audiologists (EPSDT ONLY)
Chiropractor Services	M	Chiropractors. (EPSDT or QMB recipients only)
Clinics	M D	Clinics **EXCEPTION:** Children's Dental & Children's Orthodontia (Orthodontist) Procedure Codes: 08080 (Comprehensive orthodontia treatment of adolescent dentition), 08680 (Orthontic retention-removal of appliances, construction/placement of retainers), 09430 (Office visit for obs services during regular hours)
County Health Department	M	**EXCEPTION:** County Health Department/Preventive Education
Durable Medical Equipment	M	Durable Medical Equipment-DME **EXCEPTION:** L8000, L8010, L8020 and L8030.
EPSDT Screenings	M	Procedure Codes: 99381-EP – 99395-EP Initial and Periodic EPSDT Screenings require a PMP referral. Please refer to Appendix A of the Provider Billing Manual.
FQHC Services (Federally Qualified Health Center)	M	FQHCs **EXCEPTION:** Family Planning Indicator (Y)
Glucose Test Strips/Lancet	M	Procedure Codes: A4253 (Blood Glucose Test/Reagent Strips for Home Blood Glucose per box of 50 – limited to 3 boxes per month), A4259 (Lancets, per box of 100 – limited to 2 boxes per month), A4233, A4234, A4235 and A4236 (Replacement batteries for use with medically necessary Home Blood Glucose Monitor owned by patient.) NOTE: Requires prior authorization if additional strips and/or lancets are needed.
Home Health	O	Home Health Providers **NOTE:** Inpatient services do not require a referral, however, discharge planning of outpatient services (i.e. home health, DME, specialist visits) **do require** a PMP referral.
Independent Nurse	M	Independent Nurses
Nephrology	M	**EXCEPTION:** Nephrologists-Diagnosis Code: 585.6 ICD-9 or N18.6 for ICD-10 (End Stage Renal Disease (ESRD))
Optometrist/Optician Svcs /Ophthalmologists	M	Optometrists/Opticians/Ophthalmologists), for medical diagnosis.
Outpatient Hospital Services	M O	Hospitals-Procedure Codes: 99281-99285, outpatient surgical procedures and therapies (PT, ST and OT), observation beds and non-certified emergencies. **EXCEPTION:** Outpatient Hospital Radiology (procedure codes: 70010-79999); Outpatient Hospital Lab Services (procedure codes: 36415, 80048-89399); Outpatient Hospital Chemotherapy (procedure codes: 96400-96549) Outpatient facility procedure code D9420. Outpatient facilities do not require a referral for DENTAL procedures.
Physicians	M	Physicians-any billing by physicians unless the particular provider type or service is excluded **EXCEPTION:** Anesthesiologists, Oral & Maxillofacial Surgeons, Pathologists, Radiologists/Diagnostic, Nuclear Medicine Physicians
Podiatrists' Services	M	Podiatrists (EPSDT and QMB only)

Private Duty Nurse	O	Private Duty Nurses (EPSDT only)
Psychologists' Services	M	Psychologists (EPSDT only)
Rural Health Clinics	M	Rural Health Clinics
Therapists' Services	M	Physical Therapists, Occupational Therapists and Speech Therapists. Outpatient therapy services must be a result of an EPSDT or for QMB recipients.

M=Medical (CMS 1500) I=Inpatient O=Outpatient D=Dental

39.9.2 Emergency Services

Access to certified emergency services will not be restricted by the **Patient 1st** Program. Certified emergencies in outpatient emergency room settings do not require referral or prior authorization by the PMP. However, documentation should be maintained by the provider of service to support emergency certification.

39.9.3 Certified Emergency Services

A certified emergency is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual in serious jeopardy, serious impairment to body functions, or serious dysfunction of any bodily organ or part.

The attending 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:

- The case should be handled on a situational basis. Take into consideration the person presenting, their medical background, extenuating circumstances, presenting symptoms, time of day, and availability of primary care (e.g., weekend, night or holiday.)
- Determine whether the presenting symptoms as reported would be reasonably expected to cause the patient to expect a lack of medical attention could result in an unfavorable outcome.
- Document why this case is a certified emergency. Documentation does not need to be extensive but should justify the certification.
- If not an emergency, **do not certify** the visit. Note that follow-up care should not be certified as an emergency (i.e. physical therapy, suture removal, rechecks, etc.)
- Ancillary or billing staff is not permitted to certify. Certification must be done by the attending physician.
- Children or adults brought to the ER for exam due to suspected abuse or neglect may be certified by virtue of the extenuating circumstances.

Hospitals and physicians who provide "certified emergency" services in the Emergency Room (ER) are not required to have a referral from the PMP. Please note that follow-up care should not be certified as an emergency and

in some cases may require PMP referral (i.e. physical therapy, suture removal, rechecks, etc.).

In order for the claim not to require a Patient 1st referral, there must be an "E" indicator in the appropriate claim block. Refer to the Chapter Five of the Billing Manual for further instructions.

Providers should bill certified emergency services separately from those of non-certified emergency services, which require PMP referral.

The Agency stresses the importance of coordinating with the PMPs regarding the care of Medicaid recipients in order to preserve the continuity of care and the "medical home" concept of the Patient 1st program.

39.9.4 EPSDT Services

For recipients of Medicaid, birth to age 21, the EPSDT Screening is a comprehensive preventive service at an age appropriate recommended schedule. It is the only reimbursable preventive medical service for this age group. There are numerous components of the EPSDT, all of which are required in the Federal Early Periodic Screening Diagnosis Treatment (EPSDT) program. All age appropriate components must be performed at the time of a screening exam. These components are listed and described in Appendix A of the Alabama Medicaid Provider Manual.

PMP's are requested to either perform or make arrangements for EPSDT screenings. The PMP is responsible for ensuring that age appropriate EPSDT screenings are provided. If a PMP cannot or chooses not to perform the comprehensive EPSDT screenings, the PMP may authorize another provider to perform the screenings for enrollees in the birth to 21 year age group.

If the PMP enters into an agreement with a screener in order to meet this Patient 1st requirement for participation, the agreement containing the original signatures of the PMP or the authorized representative and the screener or an authorized representative must be submitted within the enrollment application. The PMP must keep a copy of this agreement on file. If this agreement is executed after enrollment a copy must be submitted within ten (10) days of execution.

The agreement can be entered into or terminated at any time by the PMP or the screener. The Agency and DXC must be notified immediately of any change in the status of the agreement.

If there is an agreement between the PMP and a Screener to provide EPSDT services, the PMP agrees to:

- Refer Patient 1st patients for EPSDT screenings. If the patient is in the office, the physician/office staff will assist the patient in making a screening appointment with the Screener within ten (10) days.
- Maintain, in the office, a copy of the physical examination and immunization records as part of the patient's permanent record.
- Monitor the information provided by the Screener to assure that children in the Patient 1st program are receiving immunizations as scheduled and counsel patients appropriately if found in noncompliance with well child visits or immunizations.

- Review information provided by the Screener to coordinate any necessary treatment and/or follow-up care with patients as determined by the screening.
- Notify the Agency and DXC immediately of any changes to this agreement.

The Screener must agree to:

- Provide age appropriate EPSDT examinations and immunizations within sixty (60) days of the request for patients who are referred by the PMP or are self-referred.
- Send EPSDT physical examination and immunization records within 30 days to the PMP.
- Notify the PMP of significant findings on the EPSDT examination or the need for immediate follow-up care within 24 hours. Allow the PMP to direct further referrals for specialized testing or treatment.
- Notify the Agency and DXC immediately of any changes to this agreement.

Immunizations

Immunizations do not require PMP referral; however, the PMP must maintain documentation of immunizations received. Documentation must include: the date the immunization was given, the type of immunization, and who provided the immunization. PMPs are required to ensure that immunizations are up-to-date for children in their panel.

Providers should be aware that through **Patient 1st** new patients will be assigned, many of which, will be children. These children will be looking to the PMP for immunizations and/or documentation of immunizations, especially in the months prior to school starting. PMPs should be prepared to immunize these children or make arrangements to get appropriate information from the immunizing provider to meet the school rush**. ALL PMPs SHOULD MAKE EVERY EFFORT TO WORK WITH OTHER PROVIDERS IN THE COMMUNITY TO ENSURE THAT ALL CHILDREN ARE FULLY AND APPROPRIATELY IMMUNIZED**.

EPSDT Care Coordination

Effective March 1, 2004, the Alabama Medicaid Agency initiated an EPSDT care coordination service available for private and public providers. The goal of these services is to provide children with opportunities to maximize their health and development by ensuring the availability and accessibility of comprehensive and continuous preventive health services throughout childhood.

Care coordination services are available for eligible children from birth through 20 years of age at no cost to any provider who wishes to utilize them. The Agency, along with the Department of Public Health, identifies children at greatest risk who have potential for effective intervention. These Medicaid eligible recipients are targeted for outreach.

The scope of services is designed to support the physician's office personnel in identifying, contacting, coordinating services and providing office visit follow-up for children. Areas targeted include:

- Under utilization of EPSDT and immunization services,
- Vision/Hearing Screenings, including Newborn hearing screening follow-up,
- Dental Screenings,
- High utilization of Emergency Room visits,
- Elevated Blood Lead levels,
- Abnormal Sickle Cell and Metabolic Screening results,
- Referral follow-up,
- Missed appointment follow-up
- Outreach for At Risk children, and
- Teen Pregnancy Prevention Services coordination.

In addition, care coordinators are available to assist with transportation services. Care coordinators may receive referrals from physicians and dentists regarding Medically-at-Risk clients who need assistance with keeping appointments and obtaining follow-up care. Lastly, care coordinators will encourage and assist in recruiting private physicians to improve services to this population.

EPSDT care coordination services are available by contacting your local county health department. Please visit our website at www.medicaid.alabama.gov and select “Programs/Medical Services”, then select “EPSDT”. A list of EPSDT care coordinators by county and telephone numbers is available to support your office personnel.

39.10 Program Enhancements

The following enhancements are designed to help the PMP achieve the overall program goal of establishing a medical home for our recipients that is accountable and cost-effective.

39.10.1 In Home Monitoring for Disease Management

Patients with a diagnosis of Diabetes and/or Congestive Heart Failure (CHF) are eligible for enrollment in this in-home monitoring program. This program is a joint effort between the Agency, the University of South Alabama (USA) and the Alabama Department of Public Health (ADPH). The goal of the program is to decrease exacerbation episodes, emergent care visits, hospital admissions and medical costs.

Referrals for In Home Monitoring may be accepted from any source, including physicians, Patient 1st Care Coordinators, Patient Care Networks, patient or caregiver, the Health Department, hospitals, home health agencies, or community based organizations. Orders for In Home Monitoring along with the specific parameters for daily monitoring must be obtained from the patient’s PMP prior to evaluation and admission.

An ADPH Nurse Care Manager evaluates the patient, provides any needed equipment including a scale, glucometer, blood pressure cuff, and phone with a speaker. The patient data is transmitted through an automated phone system, which may be accessed through a landline or cell phone. The data is sent to a secure, web-based data collection and documentation

system developed by USACSHI named the Real-Time Medical Electronic Data Exchange (RMEDE), which is monitored by the ADPH Nurse Care Managers on a daily basis.

Alerts are generated to the ADPH Nurse Care Manager when a patient's data reports are outside their specific parameters. The Primary Medical Provider or ADPH Nurse Care Manager will follow-up with the patient and determine what services are needed.

In addition to the alert feature, the RMEDE system will generate valuable patient data reports monthly for each PMP participating in the In Home Monitoring Program. Summary data will also be provided to Medicaid for monitoring the program.

To refer a patient to the In Home Monitoring Program, contact the local Alabama Department of Public Health Home Health Agency, or call the ADPH Home Health State Office at 1-800-225-9770.

Enrollment: ADPH is enrolled with provider type 05 (home health) and provider specialty 970 (disease management).

ADPH Billing Instructions: ADPH bills on a UB-04 claim form using the following codes:

- Revenue Code: 789
- Procedure Code: G9008-U4 (ADPH Nurse Case Management)

Billing Units: 5 minutes equals one unit

39.10.2 Case Management

In regions with Health Homes, the Health Home will be able to assist the PMP managing recipients with Chronic Conditions. Statewide, the Agency partners with the Alabama Department of Public Health to provide patient intervention services. These services will be provided through social workers and will target patients who are identified as non-discriminate users of the emergency room, identified by PMPs as needing educational reinforcement and/or may have a disease state that requires extra monitoring. It is the intention that referrals will be made by the Agency as well as the PMP. These type services will be available statewide and reimbursed fee for service.

Targeted Case Management for recipients with qualifying conditions is provided by other agencies and some private providers.

39.11 Quality Assurance Activities

Quality assurance activities and program monitoring will be the responsibility of the Medicaid Managed Care Quality Assurance Program and the Patient 1st Program. Monitoring efforts will look at all facets of the program including measuring the PMP against established program goals, determining contract compliance and focusing in on program outcomes all of which involve both administrative and performance measures.

The Profile Report (Profiler) will be the central source of data for program reporting and measurement. This report is based on claims information and one is produced for each PMP. The data in the report is collected from paid claims and is processed to produce characterizations of providers, their enrollee panel and provides comparisons of providers within a peer group.

The Profiler will have three primary components:

- Individual report cards sent to each PMP to provide activity information and program measurements
- A summary report on all providers for use by the Agency. The summary information will be used to monitor the program and identify program outliers.
- Detail reports will identify program areas that need follow-up.

Program over-site activities involve monitoring both administrative measures and performance measures.

Administrative measures are collected using focused reviews and are not primarily dependent on paid claims data. These measurements focus on:

- **24/7 Medical Coverage**

  Ensures PMPs are meeting the requirement for providing after hours coverage to enrollees.

- **Referral Report**

  Monitors PMP's referral numbers to ensure appropriate usage by other providers.

- **PMP Patient Disenrollments**

  Ensures PMPs are not selectively dismissing patients so that performance measures can be met.

- **DXC Enrollment Process**

  Ensures patients are linked to the most appropriate caregiver based on patient choice, family linkage and/or historical patterns of care. This will be aimed at internal processes.

- **Complaints and Grievances**

  Ensures patients and providers have a consistent mechanism to express concerns and dissatisfaction with the Patient 1st Program or services provided through the program.

- **Recipient Targeted Survey (REOMBS)**

  Monitors the enrollee's health care experience in order to improve the Patient 1st Program and identify potential problems.

- **Cost Monitoring**

  Costs will be reviewed quarterly to ensure budget neutrality requirements are being met, to track overall costs per recipient and to track costs/savings.

Performance measures are primarily claims driven and focus on:

- **Generic Dispensing Rate**

  The percentage of generic prescriptions ordered for the Primary Medical Provider's (PMP) panel. This percentage will be compared to the performance of their peer group and risk adjusted.

- **Visits Per Unique Enrollee**

  Average number of visits per recipient seen by the PMP. The PMP's expected visit rate will be computed by weighting the performance of the PMP's peer group. The measure will compare the PMP's actual visit rate with their expected visit rate.

- **Number of Emergency Room Visits**

  Will identify PMP's that are not providing care to recipients for which they are receiving a case management fee but whose members are instead seeking care in the emergency room. This information may be used by the Agency to reassess the PMP's continued participation in the Patient 1st Program.

- **Number of Hospital days per 1000 patients**

  Will identify effective management of recipients by the PMP outside the hospital setting, especially those with chronic conditions. This is expected to result in improved patient outcomes and Agency savings.

- **Percent of Asthma patients with one or more ER visits with the primary diagnosis of Asthma**

  This is a quality measure aligning Patient 1st with established "Together for Quality" (TFQ) measures. It will identify providers who are effectively managing recipients with Asthma.

- **Percent of Diabetic patients who have had at least one HbA1c test during review period**

  This is a quality measure aligning Patient 1st with established "Together for Quality" (TFQ) measures. It will identify providers who are effectively managing recipients with Diabetes.

- **Age appropriate EPSDT screenings for 0-5 year old population**

  This will identify providers who are performing age appropriate EPSDT screenings. This reinforces early treatment and prevention while reinforcing the medical home concept.

The Agency must ensure all requirements of the Centers for Medicare and Medicaid Services (CMS) are met; therefore the above list of measures is not inclusive and may be modified.

39.12 Obtaining Forms / Educational Materials

Patient 1st forms may be obtained by accessing the Medicaid website.

NOTE:

Educational materials are also available for use by providers and may be obtained using the online ordering form on the Agency's website at www.medicaid.alabama.gov. A catalog listing these materials is also on the website.

Some materials available for download from the website include:

"Your Guide to Alabama Medicaid". This 36 page booklet describes the services covered, co-payments, the different types of eligibility, patient responsibilities, as well as other useful information.

"Alabama Medicaid Covered Services and Co-Payments" (English or Spanish). Describes services covered by Medicaid and associated co-payments.

"EPSDT Brochure". This is a colorful pamphlet that encourages Well-Child checkups and outlines the periodicity schedule.

"Are you expecting a baby?" This full colored brochure lets pregnant women enrolled in Medicaid know who to contact for prenatal care in their county of residence.

39.12.1 Medicaid Forms

The following forms can be found in Appendix E and/or on the Medicaid website www.medicaid.alabama.gov under Programs/Medical Services/Patient 1st:

- Immunization Record
- Alabama Medicaid Agency Referral Forms
- EPSDT Documentation
- Complaint/Grievance Form
- Change Your Patient 1st Personal Doctor (PMP) Form

- Newborn PMP Request Form
- Request For Educational Material
- Patient 1st Override Form
- Patient 1st Medical Exemption Form

39.13 Patient 1st Billing Instructions

Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

To bill for a service that requires a Patient 1st referral, the billing provider must have a valid signed referral form in the recipient's medical record. This form should contain the PMP's number to use for billing.

39.14 Contact Information Summary

For general Patient 1st billing questions or to request an application package call the Provider Assistance Center: 1 (800) 688-7989.

To increase the maximum number of enrollees within a caseload the request may be faxed to DXC Provider Enrollment: (334) 215-4298 or mailed to DXC Provider Enrollment, PO Box 241685, Montgomery, AL 36124

To change distance criteria or disenroll from the program the request may be faxed to DXC Provider Enrollment: (334) 215-4298 or mailed to DXC Provider Enrollment, PO Box 241685, Montgomery, AL 36124

To obtain recipient information on eligibility, benefit limits, or coverage call the Provider Assistance Center: 1 (800) 688-7989

Automated Voice Response System: 1 (800) 727-7848

To address program and policy questions, for individual or specific recipient additions or deletions, for recipient language interpretation services or to report patients enrolled in Patient 1st who should not be enrolled call the Recipient Call Center: 1(800) 362-1504

Patient 1st forms may be requested on Medicaid's website at www.medicaid.alabama.gov.

Newborn assignment forms may be faxed to DXC at (334) 215-4140.

For written correspondence to the Agency: Alabama Medicaid Agency, 501 Dexter Avenue, P.O. Box 5624, Montgomery, AL 36103-5624.