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CHAPTER ONE

GENERAL

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Chapter 1 - General

Rule No. 560-X-1-.01 Organizational Description.

The Alabama Medicaid Agency (hereinafter referred to as "Medicaid") administers the State Plan for Medical Assistance under Title XIX of the Social Security Act (hereinafter referred to as "State Plan") which provides payment for authorized medical services and supplies available to categorically eligible recipients. Certain services are mandatory under Section 1902, Title XIX of the Social Security Act. Mandatory services are defined in 42 C.F.R. Section 440.210. Certain other services are provided at the option of the State of Alabama. The optional services are defined in 42 C.F.R. Section 440.225.

Author: Kathy Hall, Deputy Commissioner, Program Administration

Authority: Social Security Act, Title XIX, Section 1902(a)(10)(A); 42 C.F.R. Section 440.210 and 440.225; and Executive Order Numbers 38, 81 and 83.

History: Rule effective October 1, 1982. Amended: Filed September 11, 2013; effective October 16, 2013.

Rule No. 560-X-1-.02 Laws and Publications Applicable to Medicaid.

The legal authorities under which the Medicaid Program is operated are:

- (1) Title XIX of the Social Security Act as amended.
- (2) 42 C.F.R. Section 430, et seq.
- (3) 45 C.F.R. Section 205, et seq.
- (4) Alabama Executive Order No. 8, dated June 30, 1967, Executive Order No. 32, dated February 17, 1972, Executive Order No. 81, dated June 16, 1977, Executive Order No. 83, dated September 26, 1977, and Executive Order No. 38, dated March 2, 1981.
- (5) Alabama State Plan for Medical Assistance under Title XIX of the Social Security Act, as approved by the Federal Department of Health and Human Services.
- (6) Section 1634, Public Law 92-603.
- (7) Code of Alabama, 1975 Sec. 22-6-1, 27-14-11,1, 35-1-2, 36-13-8, and 36-13-9, et seq.
- (8) Title VI of the Civil Rights Act of 1964, as amended.
- (9) Section 504 of the Rehabilitation Act of 1973, as amended.
- (10) The Age Discrimination Act of 1975.
- (11) Alabama Medicaid Agency Administrative Code.

(12) Alabama Medicaid Provider Manual.

(13) Provider Notices and Alerts.

(14) Clinical Laboratory Improvement Amendments of 1988 (CLIA), P.L. 100-578 (42 U.S.C. Section 263a).

Author: Theresa Richburg, Director, Medical Services Division.

Authority: All regulations cited above. **Amended** June 27, 1983; **Amended** January 13, 1993, based on OBRA '90, Section 1927.

History: Effective date of this amendment: May 13, 1993. **Amended:** Filed September 11, 2013; effective October 16, 2013. **Amended:** Filed August 11, 2016; effective September 26, 2016.

Rule No. 560-X-1-.03 Administration of the Alabama Medicaid Program.

The Alabama Medicaid Agency administers the state Medicaid Program as directed by the Governor. The head of the agency is the Commissioner, who serves at the pleasure of the Governor.

Authority: 42 C.F.R. Section 431.10; Executive Order No. 81, dated June 16, 1977, and Executive Order No. 83, dated September 26, 1977.

Rule No. 560-X-1-.04 Agencies Responsible for Medicaid Eligibility. (See Chapter 25 for detailed eligibility criteria.)

Applicants eligible for Medicaid services are certified to the Alabama Medicaid Agency by the following agencies:

(1) The Social Security Administration certifies aged, blind, and disabled applicants for the Federal Supplemental Security Income (SSI) Program. In Alabama, individuals eligible for SSI are eligible for Medicaid under Title XVI, Section 1902(b) of the Social Security Act and Section 1634, Public Law, 92-603.

(2) The Alabama Department of Human Resources (DHR) certifies eligibility at county DHR offices for some groups not eligible for SSI. These groups are discussed in Chapter 25.

(3) The Alabama Medicaid Agency certifies Medicaid eligibility for individuals listed in Chapter 25 through its certification district offices located throughout Alabama. Generally, there is no Medicaid coverage for individuals who are confined to a public institution unless it is a medical institution. See Chapter 25 for eligibility criteria and the descriptions of the groups covered.

(4) The Alabama Medicaid Agency restricts, and terminates eligibility in cases of fraud, abuse, and misuse.

Authority: Executive Order No. 83, dated September 26, 1977. Social Security Act 1902(a)(10)(A)(ii)(V) as amended by Section 9510 of COBRA 1985, 42 C.F.R. Section

431.10; Public Law 100-203, Sections 9108, 9116, and 9119; 42 C.F.R. Section 435.231; Public Law 100-360, Section 301.

History: Rule effective October 1, 1982. Amended: August 10, 1987. Emergency Rule effective January 8, 1988. Amended: April 12, 1988 and July 12, 1988. Emergency Rule effective July 1, 1988. Amended: September 9, 1988. Emergency Rule effective January 1, 1989. Amended: April 14, 1989. Effective date of this amendment: January 13, 1993.

Rule No. 560-X-1-.05 Licensure and Certification of Certain Providers.

The Bureau of Licensure and Certification, Alabama Department of Public Health is responsible, through agreement with Medicaid, for licensing hospitals, skilled and intermediate care nursing facilities, and certain other health related facilities for participation in the Medicaid program.

Authority: 42 C.F.R. Section 431.610 and 431.620; Social Security Act, Title XIX, Section 1902(a)(33); Agreement, September 14, 1980, Bureau of Licensure and Certification, Department of Public Health.

History: Rule effective October 1, 1982.

Rule No. 560-X-1-.06 Fiscal Agent.

(1) The Alabama Medicaid Agency contracts with a fiscal agent to process and pay all claims submitted by providers of medical care, services, and equipment authorized under the Alabama Title XIX State Plan.

(2) The fiscal agent will provide current detailed claims processing procedures in a manual format for all claim types covered by Medicaid services. The fiscal agent will prepare and distribute the Alabama Medicaid Agency Provider Manual to providers of Medicaid services. Such manual is guidance for providers in filing and preparing claims.

(3) Providers with questions about claims should contact the fiscal agent. Only unresolved problems or provider dissatisfaction with the response of the fiscal agent should be directed to Alabama Medicaid Agency, 501 Dexter Avenue, Montgomery, Alabama 36104, telephone number, (334) 242-5010.

Author: Kathy Hall, Deputy Commissioner, Program Administration

Authority: Title XIX, Social Security Act, Section 1902(a)(4); 42 C.F.R., Section 431.510.

History: Rule effective October 1, 1982. Amended: Filed September 11, 2013; effective October 16, 2013.

Rule No. 560-X-1-.07 Provider Rights and Responsibilities.

(1) In accordance with federal law, Medicaid providers shall ensure that no person will, on the grounds of race, color, creed, national origin, age or handicap, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program of services provided by the Agency.

(2) Compliance with Federal Civil Rights and Rehabilitation Acts is required of provider's participating in the Alabama Medicaid Program.

(3) Providers have freedom of choice to accept or deny Medicaid payment for medically necessary services rendered during a particular visit. This is true for new or established patients. 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. The fact that Medicaid payment will not be accepted must be recorded in the patient's medical record.

(4) 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, e.g. epidurals, 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. These services are covered by, and billable to Medicaid. Providers may not bill Medicaid recipients they have accepted as patients for covered labor and delivery related pain management services.

(5) 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.

(6) Providers must not restrict, impede, or interfere with the delivery of services or care coordination benefits for any Medicaid recipient whether or not the Provider is providing such care.

Author: Kathy Hall, Deputy Commissioner, Program Administration

Authority: Civil Rights Act of 1964, Titles VI and VII; Rehabilitation Act of 1973; Age Discrimination Act of 1975, and State Plan, Attachment 7.2-A.

History: Rule effective October 1, 1982. Rule Amended December 19, 1992. Effective date of this amendment March 14, 1997. Amended: Filed September 11, 2013; effective October 16, 2013. Amended: Filed September 11, 2015; effective October 16, 2015.

Rule No. 560-X-1-.08 Recipient Rights and Responsibilities.

(1) Free choice of selecting providers of health care is a legal right of every recipient of Medicaid care and services. Freedom of choice related to an individual's opportunity to make his/her own decisions for his/her own reasons, free from the arbitrary authority of others is a recipient's right.

(2) Where prior authorization is required for Medicaid services, a recipient's choice among qualified providers shall not be restricted except by special action of the Alabama Medicaid Agency to restrict or "lock-in" a recipient to a provider of choice. (See Chapters four and five for additional information on recipient restrictions.)

(3) A recipient who believes that his/her free choice of provider has been denied or impaired has the right to request a fair hearing before the Alabama Medicaid Agency.

(4) When a recipient fails to advise a provider of his/her Medicaid eligibility and furnish other information necessary to file the claim within the time allowed by Medicaid, the provider is under no obligation to file and may elect to file with Medicaid or to bill the patient.

Author: Kathy Hall, Deputy Commissioner, Program Administration

Authority: Social Security Act, Title XIX; 42 C.F.R. Section 431.51 & 431.54.

History: Rule effective October 1, 1982. Effective date of this amendment: August 10, 1987. Amended: Filed September 11, 2013; effective October 16, 2013.

Rule No. 560-X-1-.09 Recipient Identification Number.

(1) The identification number of Medicaid eligible recipients contains 13 digits. The first three will be "500" or "530".

(2) The Medicaid identification number will be embossed on a plastic Medicaid eligibility card issued to each individual entitled to Medicaid.

(3) Providers should question patients aged 65 or older about entitlement to Medicare.

(a) Where a Medicare claim number has not been assigned for those aged 65 or older, the recipient should be referred to the local SSA office to make application for Medicare.

(b) Claims for services covered by Medicare may not be submitted until a Medicare number has been assigned; then claim should be filed first with Medicare with the Medicaid number listed on the Medicare claim as "other insurance".

(c) A Medicare claim number with a suffix "M" indicates there is no Medicare Part A (hospital insurance) entitlement. Hospital claims for this type number may be filed with Medicaid as regular Medicaid claims.

Author: Kathy Hall, Deputy Commissioner, Program Administration

Authority: State Plan for Medical Assistance.

History: Rule effective October 1, 1982. Amended: May 1, 1983; June 8, 1983 and November 10, 1987. Effective date of this amendment: January 13, 1993. Amended: Filed September 11, 2013; effective October 16, 2013. Amended: Filed December 12, 2014; effective January 16, 2015.

Rule No. 560-X-1-.10 Provider Identification Number.

(1) All providers participating in the Alabama Medicaid Program are assigned an identification number by the Alabama Medicaid Agency fiscal agent.

(2) Providers must be licensed to practice in the state in which the service is rendered.

(3) Providers must have a National Provider Identifier (NPI).

Author: Kathy Hall, Deputy Commissioner, Program Administration

Authority: State Plan for Medical Assistance and the Alabama Medicaid Agency Administrative Code.

History: Rule effective October 1, 1982. Amended: May 1, 1983. Amended: Filed September 11, 2013; effective October 16, 2013.

Rule No. 560-X-1.11 Medicaid Eligibility Card.

Individuals certified eligible for Medicaid will receive a plastic Medicaid Card through the mail with the following exceptions: certain unborns; recipients certified with a pseudo number; Medicare Savings Programs other than QMB; and recipients certified for a closed period of retroactive eligibility. These individuals will receive a paper Medicaid card. Also, Medicaid recipients residing in a long term care facility will not receive a plastic Medicaid card. Each month the long term care provider will receive a computer printout listing of all Medicaid eligible recipients in the respective facility.

(1) The recipient is required to present his/her plastic Medicaid card and proper identification to a provider of medical care or services. The provider must verify eligibility through web portal, AVRS, or the Provider Inquiry Unit.

(2) Medicaid claims may be submitted for incurred charges during three months prior to the month of application. Eligibility must be established before claims submission may be paid.

(3) When a recipient loses or fails to receive a plastic eligibility card he/she should write or call the Alabama Medicaid Agency.

(a) Should the recipient require Medicaid services before receiving a replacement card he/she is responsible for furnishing his/her Medicaid number to the provider at a later time.

(b) Providers of Medicaid services shall obtain the Medicaid eligibility number directly from the recipient to verify eligibility or submit claims for services furnished the recipient. Where the Medicaid number is not available from the recipient, it may be obtained from the Medicaid Agency by sending a completed inquiry form. Providers must state in their request that they have provided authorized services, supplies, or equipment to the individual whose Medicaid number is being verified.

(c) Claims submitted for services furnished a recipient must contain all 13 digits of the recipient's Medicaid number.

(4) Providers of Medicaid services shall not submit lists of names, addresses and/or Medicaid numbers of individuals to the Alabama Medicaid Agency for verification of eligibility.

Author: Kathy Hall, Deputy Commissioner, Program Administration

Authority: State Plan; Social Security Act, Title XIX, 42 C.F.R. Section 430, et.seq. Provider Notice 82-28, September 27, 1982.

History: Rule effective October 1, 1982. Amended: May 1, 1983; July 9, 1985; August 10, 1987, and November 10, 1987. Emergency rule effective November 16, 1987.

Amended: March 12, 1988. Effective date of this amendment: January 13, 1993.
Amended: Filed September 11, 2013; effective October 16, 2013.

Rule No. 560-X-1-12 Medicaid Eligibility Termination.

(1) When a recipient is notified by the Social Security Administration that he/she is no longer eligible for Supplemental Security Income, Medicaid will send a termination notice unless he/she remains eligible for Medicaid under Alabama criteria. A recipient shall be notified at least ten days before the effective date of termination from Medicaid benefits. Chapter 28 provides two types of termination notices.

(2) In all other terminations, Medicaid and the Department of Human Resources issue Termination Notices ending Medicaid eligibility.

(3) Medicaid recipients residing in an institution may lose eligibility if they are discharged from the institution to home, or if their monthly income or resources rise above the limit for Medicaid eligibility.

(4) If a Medicaid eligible person, other than a foster child, moves permanently outside the State of Alabama, he/she will be terminated from Alabama Medicaid .

(5) Foster children will lose eligibility when they cease to be foster children.

(6) Minors eligible for Early and Periodic Screening, Diagnosis and Treatment (hereinafter called EPSDT) will lose eligibility at age 21.

(7) Medicaid recipients will lose eligibility when income exceeds the limit established for eligibility.

Author: Kathy Hall, Deputy Commissioner, Program Administration

Authority: State Plan, 42 C.F.R. Section 430, et seq.; Social Security Act, Title XIX.

History: Rule effective October 1, 1982. Amended: June 8, 1985. Effective date of amendment January 13, 1993. Amended: Filed September 11, 2013; effective October 16, 2013.

Rule No. 560-X-1-13 Medicaid Payments and Recoupments for Health Services, Supplies, and Equipment.

(1) Direct payments are made for allowable charges to providers for covered medical services and supplies furnished eligible Medicaid recipients.

Providers who wish to participate in the Alabama Medicaid Program must be enrolled, receive a provider number, and sign a contract with Medicaid.

(2) Crossover payments are partial payments to providers by Medicaid for covered Medicaid services, supplies and equipment furnished to recipients eligible for both Medicare and Medicaid.

(a) For Medicare covered services, providers of services, supplies, and equipment to eligible Medicare/Medicaid recipients must submit their claims primary to Medicare and not to the Medicaid fiscal agent.

(b) Claims paid by the Medicare contracted intermediary will be electronically forwarded to the Medicaid Fiscal agent for payment to the provider of the deductible and co-insurance charges. This is the "crossover" payment and will be listed on the provider's Medicaid Remittance Advice (RA) . Claims denied by the Medicare intermediary are not forwarded to the Medicaid fiscal agent.

(3) By entering into a contract with Medicaid, the provider acknowledges that payments thereunder are subject to review, audit, adjustment and recoupment actions. In the event of any transfer, sale, assignment, merger or replacement between and among providers, Medicaid may look both to the original provider and any successor, transferee or replacement provider for recovery of any funds improperly paid. Providers should take this right of Medicaid into account and make appropriate provision therefore in their business transactions.

(4) All sites providing laboratory testing services to Medicaid recipients, either directly by provider, or through contract, must be Clinical Laboratory Improvement Amendments (CLIA) certified to provide the level of testing complexity required. Providers are responsible to assure Medicaid that all CLIA regulations are strictly adhered to, both now and as regulations change in the future. Providers are responsible for providing Medicaid waiver or certification numbers as applicable.

(5) Laboratories which do not meet CLIA certification standards are not eligible for reimbursement for laboratory services from the Alabama Medicaid Program.

Author: Kathy Hall, Deputy Commissioner, Program Administration

Authority: Social Security Act, Title XIX, Section 1902(a)(32); 42 C.F.R. 447.10; Clinical Laboratory Improvement Amendments of 1988 (CLIA); P. L. 100-578 (42 U.S.C. Section 263a); and State Plan, Attachment 3.2-A.

History: Rule effective October 1, 1982. Effective date of this amendment January 14, 1987. Effective date of this amendment May 13, 1993. Amended: Filed September 11, 2013; effective October 16, 2013.

Rule No. 560-X-1-14 Medicaid payments for Medicare/Medicaid and/or Qualified Medicare Beneficiaries (QMB) Eligible Recipients

Medicaid pays the monthly premiums for Medicare insurance for an eligible Medicare/Medicaid and/or QMB recipient to the Social Security Administration. Medicaid also pays the applicable Medicare Part A and Part B deductibles and/or coinsurance for an eligible Medicare/Medicaid and/or QMB recipient, as specified below.

(1) Definitions

(a) "QMB" recipient is a Part A Medicare beneficiary whose verified income and resources do not exceed certain levels.

(b) "Deductible" is the dollar amount a Medicare eligible must pay for his/her own health care services.

(c) "Coinsurance" is the percentage of each bill a Medicare eligible must pay under certain conditions, in addition to the deductible amount.

(2) Part A

(a) The Part A deductible less any applicable copay or coinsurance days are covered Medicaid services. For QMB recipients, the inpatient hospital deductible less any applicable copay, coinsurance days and lifetime reserve days are covered services for any inpatient admission.

(b) Medicaid may pay the Part A coinsurance for the 21st day through the 100th day for Medicare/Medicaid and/or QMB eligible recipients who qualify under Medicare rules for skilled level of care. An amount equal to that applicable to Medicare Part A coinsurance, but not greater than the facility's Medicaid rate will be paid for the 21st through the 100th day. No payment will be made by Medicaid (Title XIX) for skilled nursing care in a dual certified nursing facility for the first 20 days of care for recipients qualified under Medicare rules.

(c) Medicare pays in full for Medicare-approved home health services, therefore, Medicaid has no liability for these services.

(d) Medicare pays in full for Medicare-approved hospice services, therefore, Medicaid has no liability for these services.

(e) Medicaid covers Medicare coinsurance days for swing bed admissions for QMB recipients. An amount equal to that applicable to Medicare Part A coinsurance, but not greater than the Medicaid swing bed rate, will be paid.

(f) Medicaid will pay Part A claims in accordance with Medicaid reimbursement methodology for Medicare recipients who have exhausted their life-time Medicare benefits. Those claims must be filed directly to Medicaid in accordance with instructions in Chapter 19 of the Alabama Medicaid Provider Manual.

(3) Part B

(a) Except as provided in this subsection, Medicaid pays the Medicare Part B deductible and coinsurance to the extent of the lesser of the level of reimbursement under Medicare rules and allowances or total reimbursement allowed by Medicaid less Medicare payment.

(b) Medicare related claims for QMB recipients shall be reimbursed in accordance with the coverage determination made by Medicare. Medicare related claims for recipients not categorized as QMB recipients shall be paid only if the services are covered under the Medicaid program.

(c) Medicare claims for rented durable medical equipment shall be considered for payment if the equipment is covered as a purchase item under the Medicaid Program. Rental payments and purchases on non-covered Medicaid items for QMB recipients shall also be considered for payment.

(4) 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 eligibles and QMB eligibles must be sent first to the Medicare contracted intermediary. Claims paid by the Medicare contracted intermediary will be electronically forwarded to Medicaid's fiscal agent for payment of the Medicare cost-sharing charges. Claims denied by the Medicare intermediary are not forwarded to the Medicaid fiscal agent. Chapter 20 of this Code contains additional health insurance information.

(a) Providers will complete the appropriate Medicare claim forms ensuring that the recipient's 13 digit Medicaid ID number is on the form. The completed

claim shall be forwarded to an Alabama Medicare carrier for payment.

(b) If the provider's claim for service is rejected by the Medicare carrier as "Medicare non-covered service" but is a covered Medicaid service, a Medicaid claim form, completed in accordance with instructions in the Alabama Medicaid Provider Manual, with a copy of the Medicare rejection statement, should be sent to the Medicaid fiscal agent for payment. QMB-Only recipients are not entitled to Medicaid coverage for Medicare non-covered services.

(c) Providers in other states who render Medicare services to Alabama Medicare/Medicaid eligibles and QMB eligibles should file claims first with the Medicare carrier in the state where the service was performed.

Author: Solomon Williams, Associate Director, Institutional Services.

Statutory Authority: State Plan, Attachment 3.2-A and 3.5-A; 42 C.F.R. § 431.625; Social Security Act of 1988 (Public Law 100-360); Balanced Budget Act of 1997.

History: Rule effective October 1, 1982. Amended November 10, 1983; March 13, 1984; June 21, 1984; January 8, 1985; April 11, 1986; January 1, 1988; February 1, 1989; May 12, 1989; January 1, 1990; June 14, 1990; February 1, 1996; April 12, 1996; November 10, 1997. Emergency rule filed and effective October 1, 1999. Amended: Filed October 13, 1999; effective January 12, 2000. Amended: Filed February 19, 2010; effective May 14, 2010. Amended: Filed September 11, 2013; effective October 16, 2013. **Amended:** Filed June 11, 2015; effective July 16, 2015.

Rule No. 560-X-1-15 Out-of-State Care and Services.

(1) Medical care and services provided outside the State of Alabama for Alabama Medicaid recipients are covered services if and only if such services are covered when rendered in-state and are medically necessary.

(a) Medical care and services which require prior authorization for in-state providers will continue to require prior authorization for out-of-state providers.

(b) Out of state providers must follow the enrollment procedures of the Alabama Medicaid Agency.

Author: Kathy Hall, Deputy Commissioner, Program Administration

Authority: State Plan; Social Security Act, Title XIX, Section 1902(a)(16) & Section 1902(a)(10)(A); 42 C.F.R. Section 431.52.

History: Rule amended effective October 13, 1992. Amended: Filed September 11, 2013; effective October 16, 2013.

Rule No. 560-X-1-16 In-State Care and Services.

(1) For each of the several categories of Medicaid covered services there may be state imposed limitations on frequency, amount, type, or kinds of services for which Medicaid will pay. Additional information concerning covered services limitation is found in the program chapters of this code.

(2) Limitations of Medicaid services and supplies may not be absolute. In individual cases of justified medical necessity they may be exceeded if prior approval is obtained from Medicaid. Chapters concerned with covered services explain how to obtain prior approval for services beyond the state's normal limit.

Authority: State Plan, Attachment 3.1-A; 42 C.F.R., Section 440.210 & 441.10; Social Security Act, Title XIX, Section 1902(a)(10)(A).

History: Rule effective October 1, 1982.

Rule No. 560-X-1-17 Providers' Claims.

(1) Providers of services and supplies shall submit claims electronically.

(2) Instructions concerning claim forms completion and processing procedures are contained in the provider manual(s) posted to the Alabama Medicaid website.

(3) Time limits for Claim Submission.

(a) Medicaid will pay only clean claims submitted timely to its fiscal agent. A clean claim is a claim which can be processed for payment or denied without obtaining additional information from the provider. A timely claim is a clean claim which is received by the fiscal agent within one year of the date of service, unless a different limitation is specifically provided elsewhere in this Code.

(b) A claim which does not have sufficient information to be entered into the automated claims processing system will be returned to the provider (RTP) and will not be considered as a clean claim submitted timely to the fiscal agent.

(c) A clean claim which is not timely received by the fiscal agent will be denied as outdated, except as provided in paragraph (4) below.

(4) Exceptions to Time Limits for Claims Submission.

(a) Where a claim has been timely submitted to Medicare or other third party payor and the Medicaid claim is not timely received in payable form by the fiscal agent in accordance with paragraph (3), above, a clean claim may still be processed if received within 120 days of the notice date of the disposition by the third party payor with such date indicated on the face of the claim. If Medicare or other third party payor denies the claim, a copy of the denial notice must be attached.

(b) Where a claim is for services rendered to a recipient during a time period for which retroactive eligibility has been awarded and the claim is not timely received in payable form in accordance with paragraph (3), above, a clean claim may still be processed if received by the fiscal agent within one year of the date of the award notice.

(c) Where a claim has been paid by Medicaid and is subsequently recouped, a resubmitted clean claim which is not timely received in payable form in accordance with paragraph (3), above, may still be processed if received within 120 days of the recoupment date, with such date indicated on the face of the claim. A copy of the EOP showing the recoupment must be attached.

(i) 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.

(d) The agency may make payments at any time in accordance with a court order, or to carry out administrative review or hearing decisions taken to resolve a dispute.

(5) Time Limits for Claims Payments.

(a) Except as otherwise provided above, the Medicaid fiscal agent must process and pay all clean claims within 12 months of receipt of the claim.

(b) A provider who submits a clean claim to the fiscal agent should normally receive payment or denial within 30 days. If payment is not received within this time period, the provider should contact the fiscal agent for a status report of the claim.

(c) When a provider's efforts to receive payment for a claim, with the help of the fiscal agent are fruitless, the provider should write to the associate director for its program at Medicaid before the time limitation expires. Providers should contact the Third Party department at Medicaid if there are problems with TPL-related claims.

(6) Administrative Review of Claims Denied as Outdated.

(a) A provider who is denied payment on an outdated claim may request an administrative review of the claim. A written request for an administrative review should be addressed to the appropriate program area and must be received by Medicaid within 60 days of the date the claim becomes outdated, which is the time limit provided in paragraph (3)(a), except that a claim falling within one of the exceptions in paragraphs (4)(a), (b) or (c), above, becomes outdated at the expiration of the 120-day or one-year period, whichever is applicable.

(b) A provider is not entitled to a fair hearing on an outdated claim until after an administrative review of the claim. A hearing request received prior to or in lieu of a request for an administrative review will be treated in all respects as a request for an administrative review.

(c) It is the responsibility of the provider, when submitting outdated claims for an administrative review, to furnish adequate documentation of its good faith attempts to obtain payment of the claim, including copies of relevant EOPs and correspondence with the fiscal agent and Medicaid. The provider must also include an error-free claim to furnish the fiscal agent in cases where the decision is favorable.

(d) Where a provider has timely requested an administrative review, research of the claim history reveals that the claim was originally filed before it became outdated under paragraph (6)(a), and the provider has established that it made a good faith effort to file a clean claim, Medicaid shall have the authority to instruct the fiscal agent to waive the filing limitation and process the claim.

(e) The provider will be notified in writing of the review decision. A provider who has timely requested an administrative review and received an adverse decision may request a fair hearing in accordance with Chapter 3 of this Administrative Code. Such request must be in writing and received by Medicaid within 60 days of the date of the administrative review denial letter. A provider is not entitled to further administrative review or a fair hearing on an outdated claim which is processed under this rule and which is denied due to a provider error on the claim.

(f) If all administrative remedies have been exhausted and the claim is denied, the provider cannot collect from either the recipient (patient) or his/her sponsor or family.

Author: Robin Arrington, LTC Provider/Recipient Services Unit, Long Term Care Division

Statutory Authority: 42 C.F.R. Section 447.45; Social Security Act, Section 1902(a)(27).

History: Rule effective October 1, 1982. Amended April 11, 1985; January 1, 1986; ER April 27, 1987; August 10, 1987; March 12, 1988; May 12, 1989, December 14, 1990 and January 13, 1993. Amended: Filed August 21, 2002, effective November 15, 2002. Amended: Filed September 11, 2013; effective October 16, 2013. **Amended:** Filed March 16, 2015; effective April 20, 2015.

Rule No. 560-X-1-18 Provider and Recipient Signature Requirements

(1) Definitions

- (a) **Designee:** Any person who can sign on behalf of the recipient. The Designee must indicate his/her relationship to the recipient next to his/her signature (e.g. spouse, power of attorney, authorized representative, etc.). The Designee's signature must be legible. If the signature is not legible, the name of the Designee should be printed next to his/her signature.
- (b) **Handwritten Signatures:** A handwritten signature is a mark or sign by an individual on a document to signify knowledge, approval, acceptance or obligation. 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 handwritten signature must be an original signature on the original record or document; it must not be a photocopy or otherwise adhered to the original document.
- (c) **Electronic or Digital Signatures:** An electronic signature validates an electronic medical record in the same way a hand written signature validates a written medical record. An electronic signature is an electronic sound, symbol, or process, attached to an electronic record and executed or adopted by a person with the intent to sign the record. The responsibility and authorship related to the signature should be clearly defined in the record. The system should be secure, allowing sole usage or password protection for each user. Digital signatures are an electronic method of a written signature that is generated by special encrypted software that allows for sole usage. Electronic and digital signatures are not the same as 'auto-authentication' or 'auto-signature' systems, some of which do not mandate or permit the provider to review an entry before signing. Therefore, "auto-authentication" or "auto-signature" systems are not allowed. Indications that a document has been 'Signed but not read' are not acceptable. Acceptable electronic or digital signatures include, but are not limited to, the following:
 - 1) Chart 'Accepted By' with provider's name
 - 2) 'Electronically signed by' with provider's name
 - 3) 'Verified by' with provider's name
 - 4) 'Reviewed by' with provider's name
 - 5) 'Released by' with provider's name
 - 6) 'Signed by' with provider's name
 - 7) 'Signed before import by' with provider's name

- 8) 'Signed: John Smith, M.D.' with provider's name
 - 9) Digitized signature: Handwritten and scanned into the computer
 - 10) 'This is an electronically verified report by John Smith, M.D.'
 - 11) 'Authenticated by John Smith, M.D'
 - 12) 'Authorized by: John Smith, M.D'
 - 13) 'Digital Signature: John Smith, M.D'
 - 14) 'Confirmed by' with provider's name
 - 15) 'Closed by' with provider's name
 - 16) 'Finalized by' with provider's name
 - 17) 'Electronically approved by' with provider's name
 - 18) 'Signature Derived from Controlled Access Password'
- (d) Stamped signatures are not accepted except in the following limited circumstances:
- 1) Claim forms as described in subsection (2)(b)(1) below;
 - 2) In accordance with the Rehabilitation Act of 1973 in the case of an author with a physical disability who can provide proof to Medicaid of his or her inability to sign his or her signature due to disability. By affixing the stamped signature, the provider is certifying that he or she has reviewed the document.
- (2) Provider Signatures—Unless otherwise specified, the signature requirements may be satisfied by a handwritten, electronic, or digital signature.
- (a) Enrollment Applications: All providers must sign an Alabama Medicaid Provider Agreement when applying for participation. By signing the Alabama Medicaid Provider Agreement, the provider agrees to keep any records necessary to disclose the extent of services the provider furnishes to recipients; to furnish Medicaid, the Secretary of HHS, or the State Medicaid fraud control unit such information and any information regarding payments claimed by the provider for furnishing services, upon request; to certify that the information on the claim is true, accurate, and complete; that the claim is unpaid; that the provider understands that payment of the 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 provider's duly authorized representative may sign the Alabama Medicaid Provider Agreement for a group practice, hospital, agency, or other institution. The duly authorized representative must have written authority to bind every member of the group practice or other entity, and such authority shall be attached to the contract.
 - (b) Claims: The provider's signature on a claim form certifies that the services billed were performed by the provider or supervised by the provider and were medically necessary.
 - 1) For paper claims, a handwritten signature by the provider on the claim form in the appropriate area or the provider's initials next to a typewritten or stamped signature is required.
 - 2) If the provider has signed the Alabama Medicaid Provider Agreement, the provider may indicate "Agreement on File" in the appropriate location on the claim form.
 - (c) Prior authorization forms:

- 1) For hardcopy requests, a handwritten signature by the provider or duly authorized representative on the form in the appropriate area is required to certify that the requested service, equipment, or supply is medically indicated and is reasonable and necessary for the treatment of his or her patient, and that a physician signed order or prescription is on file (if applicable).
 - 2) For electronic requests, an electronic or digital signature is required to certify that the requested service, equipment, or supply is medically indicated and is reasonable and necessary for the treatment of his or her patient, and that a physician signed order or prescription is on file (if applicable).
- (d) Referral forms:
- 1) For hard copy referrals, the printed, typed, or stamped name of the primary care physician with an original signature of the physician or duly authorized representative is required. Photocopied signatures will not be accepted.
 - 2) For electronic referrals, and electronic or digital signature is required.
- (e) Meaningful Use Attestation: An original signature or an electronic or digital signature shall be provided by the eligible provider or a duly authorized representative of the eligible hospital submitting the application for the incentive payment.
- (f) Orders, progress notes, and examinations: Services that are provided or ordered must be signed and dated by the ordering practitioner.
- (g) Treatment Plan Reviews: The reviewing psychologist must sign or initial and date the treatment plan being reviewed.
- (3) Recipient Signature—Unless otherwise specified, the signature requirements may be satisfied by a handwritten, electronic, or digital signature.
- (a) Recipient Signatures are required in the following instances:
- 1) All providers must obtain a signature to be kept on file as verification that the recipient was present on the date of service for which the provider seeks payment (e.g., release forms or sign-in sheets). A recipient signature is not required on individual claim forms.
 - 2) Recipient signatures are required for all pharmacy, Durable Medical Equipment (“DME”), supply, appliance and Prosthetics, Orthotics and Pedorthics (“POP”) claims to validate the billed and reimbursed service was rendered to the recipient and for pharmacy claims to ensure the recipient was offered appropriate counseling (if applicable). For pharmacy, DME, supply, appliance and POP items that have been delivered, the provider must ensure that the delivery service obtains the recipient’s signature or the signature of the recipient’s Designee.
 - 3) Hospice recipient signatures must be obtained on the Medicaid Hospice Election and Physician’s Certification (Form 165). A recipient signature is not required for each date of service for

Hospice recipients. The provider must retain documentation in the medical record to show the services were rendered.

- 4) Treatment Plans: Unless clinically contraindicated, the recipient will sign the treatment plan to document the recipient's participation in developing or revising the plan. If the recipient is under the age of 14 or adjudicated incompetent, the parent or foster parent or legal guardian must sign the treatment plan.
- (b) Recipient Signatures are not required under the following circumstances:
- 1) When there is no personal recipient or provider contact (e.g. laboratory or radiology services). This exception does not apply to pharmacy and/or DME claims. The provider must retain documentation in the medical record to show the services were rendered.
 - 2) Illiterate recipients may make their mark, for example, "X" witnessed by someone with their dated signature and printed name after the phrase "witnessed by."
 - 3) The recipient's Designee may sign claim forms for recipients who are not competent to sign because of age, mental, or physical impairment.
 - 4) A recipient signature is not required for each date of service for Home Health recipients. The Home Health provider must retain documentation in the medical record to show the services were rendered.
 - 5) When a home visit is made by a physician. The physician must retain documentation in the medical record to show the services were rendered.
 - 6) 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. The provider must retain documentation in the medical record to show the services were rendered.
 - 7) Treatment plan review, mental health consultation, pre-hospitalization screening, crisis intervention, family support, Assertive Community Treatment (ACT), Program for Assertive Community Treatment (PACT), and any non-face-to-face services that can be provided by telephone or telemedicine when provided by a Rehabilitation Option Provider or a physician meeting the telemedicine requirements as set forth in the Alabama Medicaid Administrative Code and the Alabama Medicaid Provider Manual. The provider must retain documentation in the medical record to show the services were rendered.
- (c) When payment has been made on claims for which a signature is not available and one of the above exceptions is not applicable, the funds paid to the provider covering this claim will be recouped.
- (4) The provisions of this rule shall apply unless otherwise specified in a program-specific chapter of the Alabama Medicaid Administrative Code.

Author: LaQuita Robinson, Program Manager, Hospice

Authority: State Plan, Attachment 4.19-A & D; Alabama State Records Commission; 42 C.F.R. Section 433.32.

History: Rule effective October 1, 1982. **Amended** May 15, 1983, October 7, 1983, January 1, 1984 and October 12, 1991. Effective date of this amendment May 16, 2012.

Amended: Filed September 11, 2013; effective October 16, 2013. **Amended:** Filed January 11, 2016; effective February 25, 2016. **Amended:** Filed September 9, 2016; effective October 24, 2016.

Rule No. 560-X-1-19 Sales Tax on Medicaid Paid Items.

(1) State and municipal gross sales taxes within Alabama are not to be included in charges for Medicaid covered services, medical supplies and equipment.

(2) Alabama law exempts from any state gross sales taxes all medicines prescribed by physicians when the prescription is filled by a licensed pharmacist, or sold to the patient by the physician, for human consumption or intake.

Authority: Act 81-663 of the Alabama Legislature.

History: Rule effective October 1, 1982.

Rule No. 560-X-1-20 Consent for Health Services for Certain Minors and Others.

Consent for health services for certain minors, and others will be governed by Code of Alabama, 1975, Title 22, Chapter 8.

Authority: Code of Alabama, 1975, Section 22-8.

History: Rule effective October 1, 1982.

Rule No. 560-X-1-21 Provider Medicaid Records Inspection/Audit.

(1) Alabama Medicaid providers shall keep detailed records in Alabama, 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 years plus the current year.

(2) 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. Refer to the individual provider manual chapters for detailed description of what must be included in an order.

(3) Providers shall make all such records available for inspection and audit by authorized representatives of the Secretary of Health and Human Services, 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.

(4) All providers shall, upon either verbal or written request from any agencies listed above, furnish free of charge a copy of any requested record. If the provider has no copies, the provider must allow the person requesting the copy to check out the original for copying. The provider may require that a receipt be given for any original record removed from his/her premises. If the provider does not furnish records when requested, the Agency may seek a recoupment of payment(s).

(5) 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:

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

(6) All providers are responsible for properly documenting any service that has been provided and billed to Medicaid. Documentation must indicate medical necessity and support the coding utilized. Documentation must meet practice standards and be legible for review by persons other than the provider.

(7) A mistaken entry in the record shall be corrected by a method that does not obliterate, white-out, or destroy the entry. Corrections to a record shall have the name or initials of the individual making the correction and the date of the correction.

(8) 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.

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:

- (a) Creation of new records when or after records are requested for review,
- (b) Back-dating entries,
- (c) Post-dating entries,
- (d) Pre-dating entries,
- (e) Writing over,
- (f) Adding to existing documentation (excluding appropriate late entry, addendum and/or correction entries), and/or
- (g) 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).

Author: Bakeba R. Thomas, Associate Director, Program Integrity

Authority: State Plan, Attachment 4.19-A & D; Alabama State Records Commission; 42 C.F.R. Section 433.32.

History: Rule effective October 1, 1982. Amended May 15, 1983, October 7, 1983, and January 1, 1984. Amended: Filed April 11, 2011; Effective May 16, 2012. Amended: Filed September 11, 2013; effective October 16, 2013. **Amended:** Filed June 11, 2018; effective July 26, 2018.

Rule No. 560-X-1-.22 Reserved.

Rule No. 560-X-1-.23 Payments.

(1) All payments shall be subject to the availability of appropriated funds for the Alabama Medicaid Program.

(2) Notwithstanding anything in this Code to the contrary, in the event of proration of State Funds available to the Alabama Medicaid program, payment for Medicaid benefits shall be made in accordance with provisions of the Alabama State Plan for Medical Assistance.

Authority: State Plan; Code of Alabama, 1975, Section 41-4-90.

History: Rule effective October 1, 1982.

Rule No. 560-X-1-.24 Limitations on Providers.

(1) The Alabama Medicaid Agency will normally enroll providers of covered services and issue provider contracts to new provider applicants who meet the requirements of the Code of Federal Regulations, the licensure and/or certification requirements of the State of Alabama, and the Administrative Code and operating procedures of the Alabama Medicaid Agency.

(2) Providers who have been convicted of fraud will not be considered for contract with the Medicaid Agency.

(3) The Alabama Medicaid Agency may terminate an existing contract of a provider when the Agency determines that during the last fiscal year the provider has provided services to Medicaid-only recipients not exceeding five claims and/or \$100.00 or the provider has not submitted any claims in the previous 18 months.

Author: Kathy Hall, Deputy Commissioner, Program Administration

Authority: Title XIX, Social Security Act; 42 C.F.R., Section 431.51, Section 440.230, Section 440.240, Section 442.12(d)(1), Section 447.204, Section 442.10, et seq., Section 431.107, Part 455, Subpart C, and Part 405.

History: Rule effective May 9, 1984. Amended March 11, 1985. Emergency rule effective April 16, 1987. Effective date of this amendment July 10, 1987. Amended: Amended: Filed September 11, 2013; effective October 16, 2013.

Rule No. 560-X-1-.25 Copayment (Cost-Sharing).

(1) Medicaid recipients are required to pay the designated copayment amount for the following services (including Medicare crossovers):

(a) Physician office visits (including optometric)

- (b) Inpatient hospital admissions
- (c) Outpatient hospital visits
- (d) Rural health clinic visits
- (e) Durable Medical Equipment
- (f) Medical Supplies
- (g) Pharmaceutical

(2) The copayment amount does not apply to services provided for the following:

- (a) Pregnancy
- (b) Recipients under 18 years of age
- (c) Family planning
- (d) Emergencies
- (e) Nursing Home Residents
- (f) Native Americans

(3) In addition to the exemptions in (2) above, each service has other specific exemptions. Please refer to the appropriate chapter for a complete list of the exemptions.

(4) A provider may not deny services to any eligible individual due to the individual's inability to pay the cost-sharing amount imposed.

Author: Kathy Hall, Deputy Commissioner, Program Administration

Statutory Authority: State Plan, Attachment 4.18-A; Title XIX, Social Security Act; 42 C.F.R. Section 447.50, Section 447.55, Section 447.15.

History: Rule effective June 8, 1985. Amended: Filed October 20, 2010; effective February 22, 2011. Amended: Filed September 11, 2013; effective October 16, 2013.

Rule No. 560-X-1-.26 Ancillary Services Associated with Noncovered Benefits.

(1) When a medical benefit is a noncovered service under the Alabama Medicaid Program, all ancillary charges related to delivery of that benefit are also considered noncovered.

Authority: State Plan, Title XIX of the Social Security Act, 42 C.F.R. Section 401, et seq.

History: Rule effective February 20, 1986.

Rule No. 560-X-1-.27 Organ Transplants

Alabama Medicaid will cover organ transplants under the following terms and conditions. These terms will apply to all procedures except cornea transplants.

(1) Transplants must be performed in the state of Alabama if medically available and appropriate for particular patient and transplant type with the exception of (8)(d) below.

(2) All transplant candidates must be from referrals by EPSDT or the primary physician.

(3) All transplant evaluations must be conducted by the Medicaid primary contractor. If the primary contractor is unable to perform the transplant, a referral to another facility may be made. The primary contractor will be responsible for coordination and reimbursement of referrals.

- (4) The following transplants are covered for recipients of any age:
- (a) bone marrow,
 - (b) kidney,
 - (c) heart,
 - (d) lung (single or double),
 - (e) heart/lung,
 - (f) liver,
 - (g) pancreas,
 - (h) pancreas/kidney,
 - (i) liver/small bowel,
 - (j) small bowel,
 - (k) liver/pancreas/small bowel.

(5) For EPSDT referrals, other transplants may be considered for approval if medically necessary, therapeutically effective, and non-experimental.

(6) All transplants must be prior approved by Medicaid. The primary contractor will forward a recommendation packet to Medicaid following evaluation of the recipient. Medicaid will issue notice to the recipient of approval or denial.

(7) Recipients who are denied Medicaid coverage for transplants will be offered the opportunity for a fair hearing under the provisions of Chapter Three of this code.

(8) Reimbursement

(a) Reimbursement will be a global payment established by Medicaid.

The global payment will include the following:

- 1. pre-transplant evaluation,
- 2. organ procurement,
- 3. hospital room, board, and ancillary services,
- 4. out of hospital ancillary services,
- 5. post-operative care,
- 6. pharmacy and laboratory services, and
- 7. all professional fees.

(b) Services provided after discharge will be reimbursed on a fee for service basis.

(c) Reimbursement provisions apply to transplants performed both in state and out-of-state. The global payment represents full payment for all services associated with the transplant. Recipients may not be billed for the difference between the submitted amount and the global payment.

(d) Third Party Payors: Medicaid is a payor of last resort. When a primary payor other than Medicaid has obligated to cover the transplant Medicaid may, at its discretion, approve that payor's site preference for the transplant.

(9) Cornea transplants are covered for defects (as diagnosed by ophthalmologists) which are correctable by transplant.

(10) Cornea transplants do not require prior approval.

(11) Reimbursement for cornea transplants will be normal Medicaid pricing methodology.

(12) Services associated with cornea transplants will be counted in a recipient's regular Medicaid benefit limits.

Author: Karen Smith, Associate Director, Clinic Services/Mental Health Programs.

Statutory Authority: Title XIX, Social Security Act; 42 CFR, Section 405.310(k), Section 440.10, Section 440.50, et seq; State Plan, Attachment 3.1.E and Attachment 4.19B, Section 18.

History: Rule effective June 10, 1987. Amended July 17, 1991; October 12, 1991; May 13, 1996; January 12, 1998; and January 11, 1999. Amended: Filed October 20, 1999; effective January 12, 2000. Amended: Filed May 22, 2000; effective August 10, 2000. Amended: Emergency Rule filed January 19, 2000; effective February 1, 2001. Amended: Filed January 19, 2001; effective April 18, 2001. Amended: Filed July 20, 2001, effective October 16, 2001. Amended: Filed November 12, 2013, effective December 17, 2013.

Rule No. 560-X-1-.28 Early and Periodic Screening, Diagnosis and Treatment.

(1) Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) will be available for Medicaid-eligible recipients under the age of 21 years old. This coverage will be provided for medically necessary health care, diagnosis, treatment and/or other measures described in Section 1905(a) of the Social Security Act and more specifically in Chapter 11 of the Administrative Code.

(2) The services must be necessary to correct or ameliorate a defect, physical or mental illness, or other conditions discovered during or as a result of an EPSDT screen, whether or not the services are covered or exceed benefit limits as stated in the State Plan. Misspent funds identified as a result of retrospective review will be recouped in accordance with the procedures in Chapter 4 of the Administrative Code.

Author: Kathy Hall, Deputy Commissioner, Program Administration

Authority: State Plan, Attachment 3.1-A, Title IX, Social Security Act Section 1905, 42 CFR 440.441. OBRA-89 Section 6403.

History: Rule effective December 14, 1990. Amended: Filed September 11, 2013; effective October 16, 2013.

Rule No. 560-X-1-.29 Reserved.

Rule No. 560-X-1-.30 340 B Entities.

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

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

(b) 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.

(c) 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.

(d) 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 in paragraph (b), 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.

Author: Jerri R. Jackson, Associate Director, Institutional Services Unit.

Statutory Authority: State Plan, Attachment 3.1-A and 4.19-B; Title XIX, Social Security Act; 42 CFR Section 447.205 & Section 447.331; Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508); Veterans Health Care Act of 1992 (Public Law 102-585); 42U.S.C. § 256b.

Emergency Rule: Filed and effective October 1, 2012. Amended: Filed December 11, 2012; effective January 15, 2013.