

40 Alabama Coordinated Health Network (ACHN) Primary Care Physician (PCP) and Delivering Healthcare Professional (DHCP) Billing

The Alabama Coordinated Health Network (ACHN) Manual has been developed by the Alabama Medicaid Agency to explain the policies and procedures of the ACHN program. Every effort has been made to present qualified providers a comprehensive guide to basic information concerning program requirements and billing procedures. The policies outlined in this manual are binding upon the provider. Providers should also refer to the Gainwell Provider Insiders, letters, transmittals or ALERTS regarding any updates or changes within this program.

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

40.1 ACHN Overview

The ACHN Program will effectively link recipients, providers and community resources in each of seven (7) newly-defined regions to improve health outcomes for Medicaid recipients. Care Coordination within the ACHN is a single program that will allow the Agency and Providers a more effective platform for service delivery and improved quality.

The Networks are located in the Northwest, Northeast, Jefferson and Shelby, Central, East, Southeast, and Southwest regions. The ACHN Regional Map is available on the Medicaid's website at:

https://medicaid.alabama.gov/documents/5.0_Managed_Care/5.1_ACHN/5.1.3_ACHN_Providers/5.1.3_ACHN%20Regional_Map_Contacts_Revised_9-28-20.pdf

See chart below for a listing of counties for each region:

Region	Counties
Central	Autauga, Butler, Chilton, Crenshaw, Dallas, Elmore, Lowndes, Marengo, Montgomery, Perry, and Wilcox counties
East	Blount, Calhoun, Cherokee, Clay, Cleburne, Coosa, DeKalb, Etowah, Randolph, Talladega, Tallapoosa, and St. Clair counties
Jefferson/Shelby	Jefferson, and Shelby counties
Northeast	Cullman, Jackson, Limestone, Madison, Marshall, and Morgan counties
Northwest	Bibb, Colbert, Fayette, Franklin, Greene, Hale, Lamar, Lauderdale, Lawrence, Marion, Pickens, Sumter, Tuscaloosa, Walker, and Winston counties
Southeast	Barbour, Bullock, Chambers, Coffee, Covington, Dale, Geneva, Henry, Houston, Lee, Macon, Pike, and Russell counties

Region	Counties
Southwest	Baldwin, Choctaw, Clarke, Conecuh, Escambia, Mobile, Monroe, and Washington counties

See below for ACHN Entities and their contact information:

Region	ACHN	Phone Number (Recipients)	Phone Number (Providers)	Contact Name	Email Address
Central	My Care Alabama Central	1-855-288-8360	1-855-288-8361	Casey Wylie	casey.wylie@MyCareAlabama.org
East	My Care Alabama East	1-855-288-8364	1-855-288-8366	Megan Schrimsher	megan.schrimsher@mycarealabama.org
Jefferson/ Shelby	Alabama Care Network Mid-State	1-833-296-5245	1-833-296-5245	Michael Battle	mbattle@uabmc.edu
Northeast	North Alabama Community Care	1-855-640-8827	1-855-640-8827	Dana Garrard Stout	dana.garrard@northalcc.org
Northwest	My Care Alabama Northwest	1-855-200-9471	1-855-500-9470	Stacey Copeland	stacy.copeland@MyCareAlabama.org
Southeast	Alabama Care Network Southeast	1-833-296-5246	1-833-296-5246	Kim Eason	keason@uabmc.edu
Southwest	Gulf Coast Total Care	1-833-296-5247	1-833-296-5247	Sylvia Brown	sbrown@uabmc.edu

40.2 ACHN Care Coordination Services

PCP Groups will partner with licensed social workers and nurses from the ACHN who will provide Care Coordination services. Care Coordination referrals may be requested by providers, recipients, or community sources.

The ACHN care coordinators can, among other things:

- Provide services in a setting of the recipient's choice, including provider offices, hospitals, ACHN entity office, public location, or in the recipient's home
- Help manage complex or non-compliant patients
- Perform a screening and assessment of the recipient's needs
- Assist recipients in obtaining transportation or applying for Medicaid
- Help recipients with appointments or appointment reminders
- Coordinate and facilitate referrals
- Educate or assist recipients with medication or treatment plans
- Help recipients seek care in the most appropriate setting (e.g., provider's office versus emergency room)
- Facilitate communication between the patient and care providers
- Help recipients locate needed community services

Recipients with abnormal lead levels, newborn metabolic screenings, and newborn hearing screenings will continue to receive Care Coordination from the Alabama Department of Public Health.

40.3 Agreements for Primary Care Physicians (PCPs)

40.3.1 Enrollment

Primary Care Physicians (PCPs) who want to receive Bonus Payments and ACHN Participation Rates in conjunction with the state's ACHN Program must sign **two** agreements beyond their Medicaid Enrollment. A PCP Group Enrollment Agreement with Medicaid and one agreement with an ACHN is required. The PCP must be enrolled with Medicaid as a Medicaid provider. The provider's enrollment with Medicaid and the ACHN must be fully processed as defined below to ensure bonus payments are made timely. The enrollment agreement must be on file by March 1st, June 1st, September 1st, or December 1st to ensure timely payment. Below are the guidelines for timely processing of agreements:

Medicaid PCP Group Agreement: Providers must complete and submit the agreement directly to Gainwell. The enrollment effective date for the ACHN PCP Group Agreement will be the first day of the following month, if the agreement is received and contains no errors prior to the 15th of the month. For agreements received on or after the 15th of the month, the effective date of the enrollment will be the month following the next month.

- **Example 1:** If an agreement is received by Gainwell on December 14, 2019 and contains no errors will have an enrollment effective date of January 2020.
- **Example 2:** If an agreement is received by Gainwell on December 19, 2019 and contains no errors will have an enrollment effective date of February 2020.
- **Example 3:** If an agreement is received by Gainwell on December 5, 2019 but is returned for errors. The returned agreement is sent back to Gainwell, contains no errors, and received on December 16, 2019, will have an enrollment effective date of February 2020.

ACHN PCP Network Participation Agreement: In addition to the Medicaid PCP Group Agreement, providers must complete and submit an ACHN PCP Network Participation Agreement to an ACHN to qualify for participation rates and bonus payments. Providers must sign the agreement with the ACHN. On a monthly basis, the ACHNs will notify the Agency of all executed participation agreements. The PCPs and the ACHNs must ensure that the Medicaid Group Billing ID, NPI, Medicaid ID, and name listed on the ACHN PCP Network Participation Agreement is correct and consistent with what the Agency has on the provider's Medicaid file. The provider's file must also be in an active status with the Medicaid Agency. All information submitted must be based on the group level unless the provider is set up as an individual practice. If the information is not correct or consistent, the agreement will not be added to the provider's Medicaid file. In the absence of this agreement, PCPs will not be eligible for participation rates and will not receive bonus payments. If all information communicated to the Agency is correct, the enrollment effective date for the ACHN PCP Network Participation Agreement will be the first day of the following month. Contact the ACHN you intend to participate with to inquire about submission deadlines for the PCP Network Participation Agreement.

The following provider types are eligible to participate in the ACHN program:

- Family Practitioners
- General Practitioners
- Pediatricians

- Internists
- OB/GYN
- FQHCs and RHCs are eligible to participate with ACHN as a PCP

NOTE:

When in the best interest of a patient, a nontraditional PCP may choose to enroll as a PCP with Medicaid. Other physician types may be considered for PCP participation if willing to meet all contractual and participation requirements.

Alabama Medicaid providers who are interested in participating in the ACHN program must complete and submit an **Application Package** (application and agreement) to:

NOTE:

Out-of-state Providers who are interested in participating in the ACHN program, must be within 30 miles of the Alabama state border.

1. A copy of the PCP Group Enrollment Agreement may be obtained by contacting the Provider Assistance Unit at 1-800-688-7989 or by downloading a copy by visiting www.medicaid.alabama.gov, click ACHN tab, and then click on the Provider section. Please mail completed agreements to:

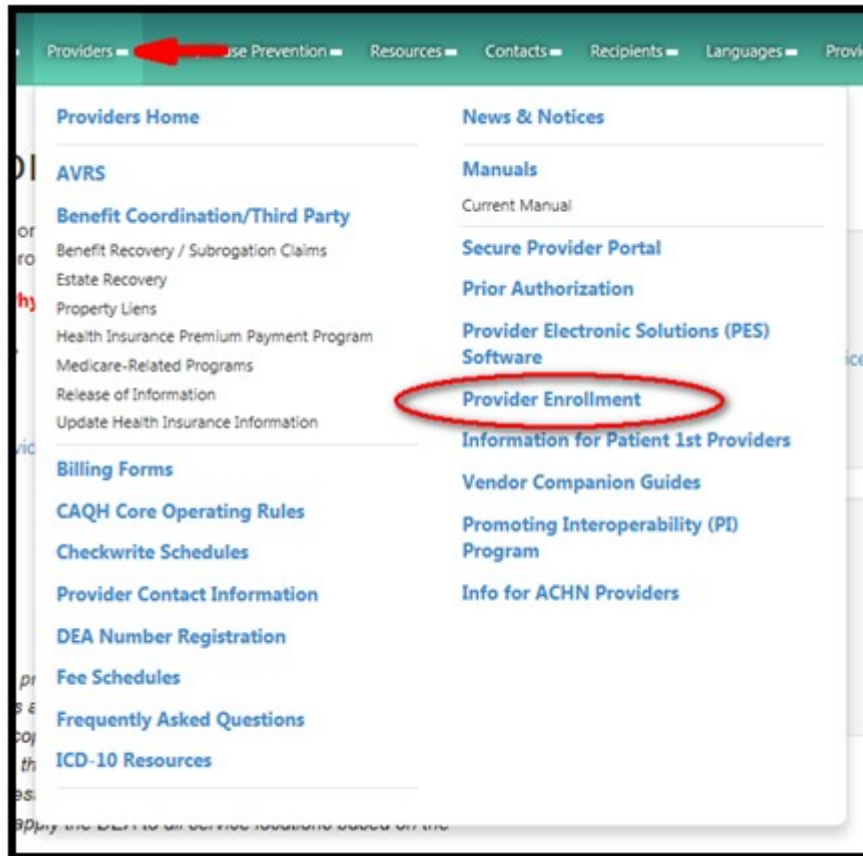
**Gainwell Provider Enrollment Unit
301 Technacenter Drive
Montgomery, AL 36117
or
P.O. Box 241685
Montgomery, AL 36124**

AND

2. To obtain the PCP Group Agreement with the ACHN, email the ACHN Regional contact that is listed in the table in section 40.1.

40.3.2 Adding a Provider to an Existing ACHN PCP Group Agreement

For providers who wish to be added to an existing ACHN PCP Group Enrollment, the provider must complete an “Individual within a Group” application. Completing this application will enroll the provider within the group that currently has a PCP Group Agreement on file. The application is submitted electronically via the application portal. This application is also the initial enrollment application for AL Medicaid. The application portal may be found at www.medicaid.alabama.gov. Go to the Providers tab, select Provider Enrollment, and click the hyperlink titled *Electronic Provider Enrollment Application Portal*. For assistance with adding the new provider to your ACHN enrollment, you may contact Provider Enrollment at 1-888-223-3630 or Provider Assistance at 1-800-688-7989.



Provider Enrollment and Forms

Federal law requires all physicians and other practitioners who prescribe or order services for Medicaid recipients, or who refer Medicaid recipients to other providers, must be enrolled as a Medicaid provider.

To download and print the ACHN Alabama Medicaid Primary Care Physician Group Enrollment Agreement, [click here](#).

Provider Enrollment Contact Information:

- (888) 223-3630 (Nationwide Toll-Free)
- Hours (All times Central) - Monday - Friday 8 a.m. to 5 p.m.
- Supervisor: Melissa Gill - (334) 215-4152 [Click here to email Provider Enrollment](#)
- [Frequently Asked Questions about Provider Enrollment](#)

Enrolling as a Medicaid Provider

- [Forms for Provider Enrollment and Re-Enrollment](#)
- [Electronic Provider Enrollment Application Portal](#)
- [Provider Enrollment Web Portal Training Manual](#)
- [Providers Required to Submit an Application Fee](#)
- [Rural Health Clinic Cost Report](#) - Useful information to help new providers establish the rate for reimbursement
- [DEA Number Registration](#) - Prescribers of controlled substances are mandated to re-register their DEA License every three years. To ensure your DEA is on file at Medicaid, upload a copy of the provider's DEA Registration Certificate to the Medicaid Interactive Web Portal or fax to (334) 215-7416 with the barcode cover sheet that is provided in the Interactive Web Portal at the end of the Enrollment Updates request. Please be sure to include the provider's name, NPI number, and license number on the certificate. Medicaid will apply the DEA to all service locations based on the provider's NPI and license number..
- [DEA Online Registration Validation](#)

40.3.3 Adding/Updating a Nurse Practitioner's or Physician Assistant's Collaborating Physician

Nurse practitioners (NPs) and physician assistants (PAs) must be collaborating with an active Medicaid enrolled physician to participate in the Medicaid program. The NP's and PA's collaborating physician must align with records from the Alabama Board of Medical Examiners (ALBME). In addition, the NP or PA, the group, and the collaborating physician must all be linked under the same group enrollment NPI. Inconsistent or incorrect collaborating physician information on the NP's or PA's Medicaid file may cause claims to deny. To add or update the collaborating physician on the NP's or PA's Medicaid file, a request must be submitted on letterhead requesting the addition or update. The letter must include the NP's name, NPI, Medicaid ID (for each location), the collaborating physician's name, collaborating physician's NPI, collaborating physician's Medicaid ID, and signature. A copy of the current collaborating license must be attached to the letter. The letter and license must be submitted through the secure web portal. For assistance with updating the NP's or PA's collaborating physician, contact Provider Enrollment at 1-888-223-3630.

40.4 PCP Determination

To be identified as a PCP for billing and referral purposes, a provider must be one of the following:

- A Teaching Facility
- A County Health Department
- A PCP group or individual participating with an ACHN
- An OB/GYN
- An FQHC
- An RHC

40.5 Requirements for PCP Active Participation with the ACHN

PCP requirements for "active participation" with one of the seven ACHNs are described below:

- In person attendance over a 12-month period to at least two quarterly medical management meetings and one webinar/facilitation exercise with the ACHN's medical director (one PCP or nurse practitioner/physician assistant from the group may attend to meet attendance requirements)
- Engagement in ACHN initiatives centered around Quality Measures
- Data review with the ACHN to help achieve Agency and ACHN Quality goals
- Engagement as appropriate in the ACHN's multidisciplinary care team and the development of an individualized and comprehensive care plan

If a PCP stops actively participating or terminates their agreement with the ACHN they signed the original agreement with, then the PCP Group must sign another agreement to actively participate with a different ACHN to continue receiving Participation Rates and Bonus payments.

In the absence of these agreements, PCP Groups will not be eligible to receive enhanced Participation Rates or Bonus Payments for Quality, Cost Effectiveness, and Patient Centered Medical Home (PCMH) recognition. If a provider chooses not to engage in active participation, they will receive regular fee-for-service rates and, if eligible, current BUMP rates.

40.6 Provider Directory

A Provider Directory is available via the Medicaid Web site to all providers and recipients to assist in selecting physicians/clinics in their regions. The Provider Directory can be used by recipients to help locate a doctor. The Provider Directory can also be used by providers to obtain contact information for referrals. Providers and recipients can filter to search by name, city, county, specialty or a combination of all. The Provider Directory is mobile and print friendly.

40.7 PCP Group/ PCP Disenrollment

The Agreement to participate in the ACHN program may be terminated by either the PCP Group or Agency, with cause or by mutual consent; upon at least 30 days written notice and will be effective on the first day of the month, pursuant to processing deadlines.

If a PCP dies, moves out of the service area, or loses Medicaid and/or **ACHN** provider status, the Agency must be notified by submitting a Disenrollment Form within 30 days of the PCP's departure.

NOTE:

For all Disenrollment situations listed above, a Disenrollment Request Form must be completed. You may obtain the form at:
http://medicaid.alabama.gov/content/9.0_Resources/9.4_Forms_Library/9.4.16_Provider_Enrollment_Forms.aspx

Disenrollment forms must be electronically uploaded to the Web Portal in PDF format. Failure to provide a 30-day notice may preclude future participation opportunities.

40.8 PCP Group Responsibilities, Functions, and Duties

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

The PCP Group shall comply with all applicable federal and state statutes and regulations, and all amendments thereto, that are in effect when the ACHN Agreement became into effect during the term of the ACHN Agreement. This includes, but is not limited to, the Alabama State Plan and Title 42 of the Code of Federal Regulations (CFR).

The PCP Group agrees to the following:

- Enter a Participation Agreement with an Entity;
- Actively Participates (refer to section 40.5) with an Entity;
- Each PCP Group physician must be a licensed physician enrolled in the Alabama Medicaid Program who has not been sanctioned.
- Be listed as a Group in the ACHN Directory for the purpose of providing care to recipients and managing their health care needs as agreed in the ACHN agreement.

- Provide services to recipients pursuant to the terms of the ACHN Agreement.
- Provide or arrange for primary care coverage, twenty-four (24) hours per day and seven (7) days per week as defined in Attachment A of the PCP Group Agreement, for services, consultation, management or referral, and treatment for emergency medical conditions. Automatic referral to the hospital emergency department for services does not satisfy this requirement. The PCP Group must have at least one telephone line that is answered by the office staff during regular office hours.
- Provide EPSDT preventive care screenings to Medicaid eligible children age birth through 20. PCP Groups serving this population who do not provide EPSDT services are required to sign an agreement with another provider to provide EPSDT services. PCP Groups must retain a copy of this agreement in their files and must ensure that their records include information regarding the extent of these services.
- Provide hospital admissions. (Refer to section 40.8.1: Hospital Admitting Privileges Requirement)
- Maintain a unified patient medical record for each recipient following the medical record documentation guideline as defined by Medicaid Policy in Rule No. 560-X-1-.21 of the Alabama Medicaid Administrative Code and policy.
- Promptly arrange referrals for medically necessary health care services that are not provided directly and document referral for specialty care in the medical record. Provide the NPI to the consulting provider.
- Transfer the recipient medical record to the receiving PCP Group at the request of the new PCP Group and as authorized by the recipient within thirty (30) days of the date of the request. Recipients cannot be charged for copies of medical records.

NOTE:

Patients must request their records be transferred to the new PCP Group and must not be charged a fee for this service.

- Authorize care for the recipient or see the recipient based on the standards of appointment availability as defined by policy.
- Refer for a second opinion as defined by policy.
- Review and use all recipient utilization, quality improvement, and other reports provided by the Agency and/or Entity for the purpose of practice level utilization management, quality of care improvement, and advise the Agency of errors, omissions, or discrepancies.
- Participate with Agency utilization management, quality assessment, complaint and grievance, and administrative programs.
- Provide the Agency or its duly authorized representatives and appropriate Federal Agency representatives unlimited access (including onsite inspections and review) to all records relating to the provision of services under the PCP Group agreement as required by Medicaid policy in Rule No. 560-X-1-.21 of the Alabama Medicaid Administrative Code and 42 C.F.R. § 431.107.

- Maintain reasonable standards of professional conduct and provide care in conformity with generally accepted medical practice following national and regional clinical practice guidelines.
- Notify the Agency of all changes to information provided on the initial application for participation in the ACHN Program. If such changes are not reported within thirty (30) days of change, future participation may be limited.
- Give written notice of termination of ACHN Agreement to each recipient who received his or her primary care from, or was seen on a regular basis, by the PCP Group within thirty (30) days after receipt of the termination notice or within thirty (30) days of notice of termination.
- Retain records in accordance with requirements of Rule No. 560-X-1-.21 of the Alabama Medicaid Administrative Code after the final payment is made and all pending matters closed, plus additional time if an audit, litigation, or other legal action involving the records is started before the original retention period ends.
- Comply with all Federal and State laws and regulations including Title VI of the Civil Rights Act of 1964, Title IX of the Education of Amendments of 1972 (regarding education programs and activities), the Age Discrimination Act of 1975, the Rehabilitation Act of 1973, and the Americans with Disabilities Act.
- Receive prior approval from the Agency of any ACHN specific, or education materials prior to distribution.
- Make oral interpretation services available free of charge to each potential enrollee and enrollee. This applies to all non-English languages.

NOTE:

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

- Provide the Agency with at least thirty (30) days prior notice of PCP Group disenrollment, change in practice site, Medicaid Group Billing ID, or NPI changes to allow for notification to recipients. Failure to provide thirty (30) day notice may preclude future participation.
- Have the ability to provide comprehensive whole-person care that includes a comprehensive health care assessment (including mental health and substance use), coordination and access to preventive and health promotion services, including prevention of mental illness and substance use disorders, medical and health care services informed by evidence-based clinical practice guidelines, mental health, substance abuse, and developmental services, and chronic disease management, including self-management support to individuals and their families, and interventions.
- Have the ability to provide continuity of personal clinician assignment and clinician care, organization of clinical information, clinical information exchange, and specialized care settings.
- Have the capacity to provide culturally appropriate, and person- and family-centered services, coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services, and provide a positive experience of care.

- Upon termination of the Agreement, the PCP Group must supply all information necessary for reimbursement of outstanding Medicaid claims.

The PCP Group is prohibited from the following:

- Discriminating against Recipients on the basis of health status or the need for health care services.
 - Discriminating against Recipients on the basis of race, color, or national origin and will refrain from using any policy or practice that has the effect of discriminating on the basis of race, color, or national origin.
 - Refrain from knowingly engaging in a relationship with the following:
 1. An individual who is debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549; or
 2. An individual who is an affiliate, as defined in the Federal Acquisition Regulation.

Note: The relationship is described as follows:

- a. As a director, officer, partner of the PCP Group; or
- b. A person with beneficial ownership of more than five percent (5%) or more of the PCP Group's equity; or
- c. A person with an employment, consulting or other arrangement with the PCP Group for the provision of items and services which are significant and material to the PCP Group's contractual obligation with the Agency.

40.8.1 Hospital Admitting Privileges Requirement

- PCP Group is required to establish and maintain hospital admitting privileges or have a formal arrangement with a hospitalist group or another physician or group for the management of inpatient hospital admissions that addresses the needs of all recipients. If a Group does not admit recipients, then the Hospital Admitting Agreement must be submitted to the Agency to address this requirement for participation. If the PCP Group has entered a formal arrangement for inpatient services, this form must be completed by both parties, and the applicant must submit the original form with the Application for enrollment or resubmit within ten (10) days of when a change occurs regarding the PCP Group's management of inpatient hospital admissions.
- A formal arrangement is defined as a voluntary agreement between the PCP Group and the agreeable physician/group. The agreeable party is committing in writing to admit and coordinate medical care for the recipient throughout the inpatient stay. Admitting privileges or the formal arrangement for inpatient hospital care must be maintained at a hospital that is within a forty-five (45) minutes' drive time from the PCP Group's practice. If there is no hospital that meets the above geographical criteria, the hospital geographically closest to the PCP Group's practice will be accepted.

- Exception may be granted in cases where it is determined the benefits of a PCP Group's participation outweigh the PCP Group's inability to comply with this requirement.

See Attachment B of Alabama Medicaid Primary Care Physician Group Enrollment Agreement for more information on the Hospital Admitting Requirements.

40.8.2 24/7 Coverage Requirement

- The PCP Group must provide recipients with after-hours coverage. It is important that recipients be able to contact their PCP Group to receive instruction or care at all times, so that care will be provided in the most appropriate manner to the recipient's condition. After hours coverage must be available 24 hours a day every day of the year. The PCP Group can meet this requirement through a variety of methods. To qualify as an ACHN PCP Group, one of the following must be met:
 - The after-hours telephone number must connect the patient to the PCP Group's physician or an authorized medical practitioner.
 - The after-hours telephone number must connect the recipient to a live voice call center system or answering service who will either direct the recipient to the appropriate care site or contact the PCP Group's physician or PCP Group's authorized medical practitioner. If the PCP Group's physician or authorized medical practitioner is contacted, then the recipient should receive instructions within one (1) hour.
 - The after-hours telephone number can connect to a hospital if the PCP Group has standing orders with the hospital to direct recipients to the appropriate care site. (For example, if the recipient's symptoms are such that the recipient can be seen the next morning, the hospital should direct the recipient to contact the PCP Group in the morning to make an appointment).

An office telephone line that is not answered after hours or answered after hours by a recorded message instructing recipients to call back during office hours or to go to the emergency department for care is not acceptable. It is not acceptable to refer recipients to the PCP Group's home telephone if there is not a system in place as outlined above to respond to calls. Systems designed to refer all requests to go physically to the Emergency Room are not acceptable. Failure to comply with the 24/7 coverage requirements may affect future participation opportunities. See Attachment A of Alabama Medicaid Primary Care Physician Group Enrollment Agreement for more information on the 24/7 Coverage Requirements.

40.8.3 EPSDT Requirement

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

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

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

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

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

- Refer patients for EPSDT screenings. If the patient is in the office, the physician/office staff will assist the patient in making a screening appointment with the Screener within ten (10) days.
- Maintain, in the office, a copy of the physical examination and immunization records as part of the patient's permanent record.
- Monitor the information provided by the Screener to assure that children in the ACHN program are receiving immunizations as scheduled and counsel patients appropriately if found in noncompliance with well child visits or immunizations.
- Review information provided by the Screener to coordinate any necessary treatment and/or follow-up care with patients as determined by the screening.
- Notify the Agency and Gainwell immediately of any changes to this agreement.

The Screener must agree to:

- Provide age appropriate EPSDT examinations and immunizations within sixty (60) days of the request for patients who are referred by the PCP or are self-referred.
- Send EPSDT physical examination and immunization records within 30 days to the PCP.

- Notify the PCP of significant findings on the EPSDT examination or the need for immediate follow-up care within 24 hours. Allow the PCP to direct further referrals for specialized testing or treatment.
- Notify the Agency and Gainwell immediately of any changes to this agreement.

40.9 Standards of Appointment Availability and Office Wait Times

The PCP Group must conform to the following standards for appointment availability:

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

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

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

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

40.10 PCP Medical Records Guidelines

Medical records should reflect the quality of care received by the recipient. However, many times medical records documentation for the level of care provided varies from provider to provider. Therefore, in order to promote quality and continuity of care, a guideline for medical record keeping has been established. All ACHN PCP Groups must implement the following guidelines as the standards for medical record keeping:

1. Each page, or electronic file in the record, contains the recipient's name or recipient's Medicaid identification number.
2. All entries are dated.
3. All entries are identified as to the author.
4. The record is legible to someone other than the writer, including the author.
5. Medication allergies and adverse reactions are prominently noted and easily identifiable as well as the absence of allergies.
6. Personal and demographic data is recorded and includes age, sex, address, employer, home and work telephone numbers, and marital status.
7. Past medical history is easily identified including serious accidents, operations, and illnesses. For children, past medical history relates to prenatal care and birth.
8. There is a completed immunization record.

9. Diagnostic information, medication, medical conditions, significant illnesses, and health maintenance concerns are recorded in the medical record.
10. Notation concerning smoking, alcohol, and other substance abuse is present.
11. Notes from consultations are in the record. Consultation, lab, and X-ray reports filed in the chart have the ordering provider's initials or other documentation signifying review. Consultation and significantly abnormal lab and imaging results have an explicit notation in the record of the follow-up plans.
12. Emergency care is documented in the record.
13. Discharge summaries are included as part of the medical record for hospital admissions.
14. Documentation of individual encounters that provide adequate evidence of appropriate history, physical examination, diagnosis, diagnostic test, therapies, and other prescribed regimen, follow-up care, referrals and results thereof, and all other aspects of patient care, including ancillary services.

40.11 Recipient Education

Recipient education will be an integral part of the ACHN Program to help the recipients understand the program and their responsibilities. All educational materials should stress the importance of contacting the PCP Group before receiving services that require a referral, versus services that do not require a PCP referral. It is also imperative to stress the importance of contacting the ACHN and/or the Recipient Call Center (RCC) (1-800-362-1504) number anytime there is a question.

In addition, as the coordinator of care, it is important for PCP Groups to be actively involved in patient education. PCP Groups are encouraged to contact all new recipients by telephone or in writing.

Providers should address the following subjects with each new recipient:

- The PCP Group's requirement to provide medical advice and care 24 hours per day, 7 days per week and the preferred method for contacting the PCP Group
- The requirement that the recipient contact the PCP Group for a referral before going to any specialist
- The requirement that the recipient must contact the PCP Group before going to the emergency room unless the recipient feels that his/her life or health is in immediate danger
- The importance of regular preventive care visits such as Well Child Check-ups EPSDT screenings for children, immunizations, check-ups, mammography, cholesterol screenings, adult health assessments, and diabetic screenings
- The availability of additional information for recipients from the ACHN or the Agency's Recipient Call Center

40.12 Agreement Violation Provisions

Failure to meet the terms outlined in the ACHN PCP Group Enrollment Agreement or other provisions of the Medicaid Program governed under Social Security Act Sections 1932, 1903(m) and 1905(t) may result in the following actions by the Agency:

- Referral to the Agency's Program Integrity for investigation of potential fraud

- Referral to the Board of Medical Examiners or other appropriate licensing board
- Termination of the PCP Group from the Alabama Medicaid Program

40.13 BMI Requirement

Primary Care Physicians (PCPs), nurse practitioners and physician assistants collaborating with a PCP, a PCP group or individual participating with an ACHN, Federally Qualified Health Centers (FQHCs), Rural Health Centers (RHCs), Public Health Departments, and OB/GYNs that bill procedure codes 99201-99205, 99211-99215, and 99241-99245 must include an annual BMI diagnosis on the claim or the claim will be denied. EPSDT procedure codes 99382-99385 and 99392-99395 must also include an annual BMI diagnosis on the claim or the claim will be denied. If a BMI has been reported on a recipient for the current calendar year (January 1 – December 31), the claim will pay without a new BMI. If the BMI has not been reported on the recipient for the current calendar year, a BMI will be required for the claim to pay. For additional information on changes to the BMI Requirement, see the *Changes to BMI Requirement* ALERT on the Alabama Medicaid Agency's website.

Medicaid ALERTs: <https://medicaid.alabama.gov/alerts.aspx>

In instances where a BMI cannot be determined (e.g., wheelchair bound recipients) a BMI override request may be submitted after the claim has been filed and denied. See section 40.15 for Override request procedures.

The table below provides a description of procedure codes and ICD-10 codes that require a percentile on the CMS 1500 claim form for **recipient's age 3-19 years**:

Procedure Code Description	ICD-10 Diagnosis Code Description for Ages 3-19
99201 Office/Outpatient Visit New	Z6851 BMI Pediatric, Less Than 5th Percentile for Age
99202 Office/Outpatient Visit New	Z6852 BMI Pediatric, 5th Percentile to Less Than 85% for Age
99203 Office/Outpatient Visit New	Z6853 BMI Pediatric, 85% To Less Than 95th Percentile for Age
99204 Office/Outpatient Visit New	Z6854 BMI Pediatric, Greater Than or Equal To 95% for Age
99205 Office/Outpatient Visit New	
99211 Office/Outpatient Visit Est	
99212 Office/Outpatient Visit Est	
99213 Office/Outpatient Visit Est	
99214 Office/Outpatient Visit Est	
99215 Office/Outpatient Visit Est	
99241 Office Consultation	
99242 Office Consultation	
99243 Office Consultation	
99244 Office Consultation	
99245 Office Consultation	
99382 EPSDT New Patient	
99383 EPSDT New Patient	
99384 EPSDT New Patient	
99385 EPSDT New Patient	
99392 EPSDT Est Patient	
99393 EPSDT Est Patient	

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Procedure Code Description	ICD-10 Diagnosis Code Description for Ages 3-19
99394 EPSDT Est Patient 99395 EPSDT Est Patient	

NOTE:

For Pediatric BMI reporting: The same BMI code may be appended to the claim until the next well child check (where a BMI is typically determined) unless the physician considers the clinical need for a BMI redetermination sooner than the next well child check.

The table below provides a description of procedure codes and ICD-10 codes that require a BMI on the CMS 1500 claim form for **recipients age 20 and older**:

Procedure Code Description	ICD-10 Diagnosis Code Description For Ages 20 and Older
99201 Office/Outpatient Visit New	Z681 Body Mass Index (BMI) 19 Or Less, Adult
99202 Office/Outpatient Visit New	Z6820 Body Mass Index (BMI) 20.0-20.9, Adult
99203 Office/Outpatient Visit New	Z6821 Body Mass Index (BMI) 21.0-21.9, Adult
99204 Office/Outpatient Visit New	Z6822 Body Mass Index (BMI) 22.0-22.9, Adult
99205 Office/Outpatient Visit New	Z6823 Body Mass Index (BMI) 23.0-23.9, Adult
99211 Office/Outpatient Visit Est	Z6824 Body Mass Index (BMI) 24.0-24.9, Adult
99212 Office/Outpatient Visit Est	Z6825 Body Mass Index (BMI) 25.0-25.9, Adult
99213 Office/Outpatient Visit Est	Z6826 Body Mass Index (BMI) 26.0-26.9, Adult
99214 Office/Outpatient Visit Est	Z6827 Body Mass Index (BMI) 27.0-27.9, Adult
99215 Office/Outpatient Visit Est	Z6828 Body Mass Index (BMI) 28.0-28.9, Adult
99241 Office Consultation	Z6829 Body Mass Index (BMI) 29.0-29.9, Adult
99242 Office Consultation	Z6830 Body Mass Index (BMI) 30.0-30.9, Adult
99243 Office Consultation	Z6831 Body Mass Index (BMI) 31.0-31.9, Adult
99244 Office Consultation	Z6832 Body Mass Index (BMI) 32.0-32.9, Adult
99245 Office Consultation	Z6833 Body Mass Index (BMI) 33.0-33.9, Adult

	Z6834	Body Mass Index (BMI) 34.0-34.9, Adult
	Z6835	Body Mass Index (BMI) 35.0-35.9, Adult
	Z6836	Body Mass Index (BMI) 36.0-36.9, Adult
	Z6837	Body Mass Index (BMI) 37.0-37.9, Adult
	Z6838	Body Mass Index (BMI) 38.0-38.9, Adult
	Z6839	Body Mass Index (BMI) 39.0-39.9, Adult
	Z6841	Body Mass Index (BMI) 40.0-44.9, Adult
	Z6842	Body Mass Index (BMI) 45.0-49.9, Adult
	Z6843	Body Mass Index (BMI) 50-59.9, Adult
	Z6844	Body Mass Index (BMI) 60.0-69.9, Adult
	Z6845	Body Mass Index (BMI) 70 or Greater, Adult

Some specialties are exempt from the BMI requirement. The table below lists provider specialties that are excluded from the BMI requirement:

Spec	Description	Spec	Description
021	Cardiac Electrophysiology	332	Otologist, Laryngologist, Rhinologist
023	Sports Medicine	337	Plastic Surgeon
180	Optometrist	339	Psychiatrist
310	Allergist	340	Pulmonary Disease Specialist
311	Anesthesiologist	341	Radiologist
312	Cardiologist	342	Thoracic Surgeon
313	Cardiovascular Surgeon	343	Urologist
314	Dermatologist	750	Colon and Rectal Surgery
317	Gastroenterologist	760	EENT
319	General Surgeon	770	Endocrinologist
321	Hand Surgeon	780	Hematology
324	Nephrologist	790	Infectious Disease
325	Neurological Surgeon	810	Orthopedic
326	Neurologist	830	Rheumatology
329	Oncologist	922	Perinatologist High-Risk Pregnancy
331	Orthopedic Surgeon		

NOTE:

Pregnant women with a pregnancy diagnosis code are excluded from the BMI requirement.

40.14 Referral Requirements

PCP to PCP referrals are not required. For most specialty services, a referral from a PCP or an ACHN Network is required. The referral to the specialist may be provided by any PCP. The referral does not have to be provided by the attributed provider that is listed on the eligibility verification. EPSDT referrals will continue to be required. Recipient eligibility screens will display the date of the last screening and the attributed provider for the recipient. Referral requirements may apply to either Professional or Outpatient claims. To determine the provider types that are identified as PCPs, refer to section 40.4: PCP Determination.

NOTE:

Cascading Referral - After evaluation, consultant may, using PCP's NPI, refer recipient to another specialist as indicated for the condition identified on the referral form without having to get an additional referral from the PCP.

NOTE:

Referrals to specialist/consultants can also be authorized by Physician extenders (e.g. Nurse Practitioners, Physician Assistants). The Physician extenders must be collaborating with a physician that is identified as a PCP in order for claims to pay.

40.14.1 Referrals for Specialty Providers Associated with Teaching Facilities

Alabama Medicaid providers who are considered teaching specialty providers may provide services to Medicaid recipients without a Primary Care Physician (PCP) referral. Medicaid claims can be processed for payment without a referral, however, the absence of communication between PCPs and specialists may hinder optimal coordination of medical care. Therefore, communication is encouraged. The Early Periodic Screening, Diagnosis, and Treatment (EPSDT) referral remains in place to assist with managing the fourteen-office visit limit. For more information regarding referrals for Specialty Providers Associated with Teaching Facilities, you may access the Teaching Facility Referrals in the ACHN one-pager with the following link:

https://medicaid.alabama.gov/documents/5.0_Managed_Care/5.1_ACHN/5.1.3_ACHN_Providers/5.1.3_Teaching_Facility_Referrals_ACHN_10-31-19.pdf.

40.14.2 Referral Form

All referrals must be documented on the *Alabama Medicaid Agency Referral Form (Form 362)*.

- 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.

- The Physician’s NPI number on the Referral (Form 362) can be the NPI of the original referring PCP or the NPI of the original referring group.
- For electronic referrals, an electronic or digital signature is required.

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

40.14.3 Referral Process for PCP to Specialist/Consultant

Coordination of care is an important part of the PCP referral process. PCPs may refer a patient 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.

In some cases, the PCP may choose to authorize a service retroactively. All referrals, including services authorized retroactively, are at the discretion of the PCP.

NOTE:

Some services do not require referral (e.g., administration of allergy injections, ambulance services, certified emergencies, radiology services, laboratory services). Some provider types also do not require a referral including county health departments, Children’s Rehab Services (CRS), hospitals, independent radiologists, pathologists, and dermatologists. See tables below to determine if a PCP referral is or is not required for services.

SERVICES NOT REQUIRING A PCP 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 for Diagnosis Code: N18.6 ICD-10 (End Stage Renal Disease)
EPSDT Developmental DiagnosticAssessment	M	Procedure Codes: 96110 & 96111 (EPSDT Developmental Assessment) and 99381-EP – 99395-EP Initial and Periodic EPSDT Screenings
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)
Family Planning	M O	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 (Laparoscopy), 57170 (Diaphragm fitting), Depo Provera; Diagnosis Codes: Z30011–Z309 for ICD-10 (Contraceptive Management)
Gynecology/Obstetrics	M	OB/GYN-Any service performed by this specialty is exempt from referral requirement.
HCBS Services	M	Providers of HCBS waived 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 Immunization section 40.27 in this chapter for more details).
Infant Birth Diagnosis	ANY	Diagnosis Codes: Z38.00-Z38.8 for ICD-10 (Single Live born)
Inpatient Consults	M	Procedure Codes: 99251-99263 (Initial inpatient consult), 99360 (Physician Standby), 99436 (Attendance at delivery)
Inpatient Hospital <ul style="list-style-type: none"> • General • Psychiatric • Physician Hospital Visit 	I	Hospital
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) <ul style="list-style-type: none"> Intermediate Care Facility-Mentally Retarded (ICF-MR) Nursing Home 	I	Nursing Homes & ICF-MR Facilities
Maternity Services	M O	Diagnosis Codes 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. PCP 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 PCP referral)
Pregnancy-Related Services	M O I	Diagnosis Codes: O20.0-O9A.53 for ICD-10 (Pregnancy-related), 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), 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 Cardiology), 93237 (Physician review/report), 93300-93399 (Echo)
Radiology	M	Independent Radiologists & Hospitals (Claim Type OP) Outpatient Hospital Radiology-procedure codes: 70010-79999 (Diagnostic Radiology)
Specialists	M	Anesthesiologists, Dermatologists, Oral & Maxillofacial Surgeons, Pathologists, Radiologists/Diagnostic, Nuclear Medicine Physicians **All other physicians require referral in any office or outpatient setting.

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

SERVICES REQUIRING PCP 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 (other than Anesthesiologists)
Audiologists' Services	M	Audiologists (EPSDT ONLY)
Behavior Health Providers (Licensed Psychologists and Licensed Social Workers)	M	A PCP referral is required for recipients under the age of 21 (ONLY if referred as a result of an EPSDT screening) and QMB recipients.
Children's Orthodontia	M D	EXCEPTION: Children's Dental & Children's Orthodontia (Orthodontist) Procedure Codes: 08080 (Comprehensive orthodontia treatment of adolescent dentition), 08680 (Orthodontic retention-removal of appliances, construction/placement of retainers), D9430 (Office visit for obs services during regular hours)
Chiropractor Services	M	Chiropractors. (EPSDT or QMB recipients only)
Durable Medical Equipment	M	Durable Medical Equipment-DME EXCEPTION: L8000, L8010, L8020 and L8030.
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: Discharge planning of outpatient services (i.e. home health, DME, specialist visits) do require a PCP referral.
Independent Nurse	M	Independent Nurses
Nephrology	M	EXCEPTION: Nephrologists-Diagnosis Code: N18.6 for ICD-10 (End Stage Renal Disease (ESRD))
Optometrist/Optician Svcs /Ophthalmologists	M	Optometrists/Opticians/Ophthalmologists), for medical diagnoses.
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.
Specialists	M	Specialists-any billing by specialists unless the particular provider type or service is excluded.
Podiatrists' Services	M	Podiatrists (EPSDT and QMB only)
Private Duty Nurse	O	Private Duty Nurses (EPSDT only)
Therapy 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

40.14.4 ACHN Billing Referral

An “ACHN Billing Referral” to a specialist/consultant may be needed in certain instances such as when a recipient has been referred by an emergency room physician to a specialist/consultant and the recipient does not have a PCP. In these instances, the ACHN must be contacted by the specialist for an ‘ACHN Billing Referral’. The ACHN will document on Medicaid’s Referral Form 362 “For Billing Purposes Only” in the space provided under REFERRAL VALID FOR. The ACHN will encourage the recipient to enroll into active care coordination to ensure the recipient finds a PCP as quickly as possible.

In addition to the PCP 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.

40.14.5 Oncology and Hematology Referrals

PCP referrals to oncologists and hematologists are required for reimbursement. If the recipient does not have a PCP or a PCP cannot be identified, the oncologists and hematologists may contact the ACHN that the

recipient is assigned to for a temporary “for billing purposes only” referral. The ACHNs will work with the oncologists, hematologists, and the recipient in care coordination services.

40.14.6 Breast & Cervical Cancer (BCC) Provider Referrals

Breast & Cervical Cancer (BCC) network providers participating in the Alabama Breast and Cervical Cancer Early Detection Program must receive a temporary ‘billing purposes only’ referral from the recipient’s Alabama Coordinated Health Network (ACHN) to provide services. The BCC network provider must seek the referral prior to initiating treatment. The ACHN will provide the temporary ‘billing purposes only’ referral within two (2) business days of the request. The referral will cover six (6) months of care.

To further prevent the recipient from going over the fourteen (14) visit limitation, BCC providers can also issue referrals to other providers to manage the care of the recipient.

Optional: If the BCC network provider would like the opportunity to receive bonus payments, a Primary Care Physician (PCP) Group Agreement must be completed with the Agency and an additional participation agreement with the ACHN must also be completed. The PCP Group Agreement may be obtained from the Medicaid website. The BCC network provider must contact the ACHN for the participation agreement.

40.14.7 Non-Breast & Cervical Cancer (BCC) Provider Referrals

The Non-BCC network providers must receive a temporary ‘billing purposes only’ referral from the recipient’s Alabama Coordinated Health Network (ACHN) to provide services. The non-BCC oncology/hematology provider may avoid the ACHN billing referral requirement before initiating treatment, by enrolling with Medicaid as a Primary Care Physician (PCP). By signing Medicaid’s PCP Group Agreement, the provider will be able to provide services without a referral and provide a referral to other specialists when needed.

Optional: If the non-BCC network oncology/hematology provider would like the opportunity to receive bonus payments, a Primary Care Physician (PCP) Group Agreement must be completed with the Agency and an additional participation agreement must be completed with the ACHN. The PCP Group Agreement may be obtained from the Medicaid website. The non-BCC network oncology/hematology provider must contact the ACHN for the participation agreement.

Provider	Responsibilities:
<p>BCC Network Provider</p>	<ul style="list-style-type: none"> • Seek Billing Referral from ACHN prior to initiating treatment • Every 6 months check in with the ACHN on status of treatment or to request new referral • Will be able to provide referrals to other providers as necessary to manage care of recipient • Work with the ACHN to ensure care coordination services for patients are provided as appropriate • <i>Optional:</i> If they want to be able to receive bonus payments, sign PCP Agreement and ACHN Participation Agreement
<p>Non-BCC Network Providers and Oncologists and Hematologists</p>	<ul style="list-style-type: none"> • Seek Billing Referral from PCP or from ACHN (ACHN may provide a 6-month billing referral) • Every 6 months check in with the ACHN on status of treatment or to request new referral • Work with the ACHN to ensure care coordination services for patients are provided as appropriate • <i>Optional:</i> If they want to be able to provide their own referrals, they must sign a PCP Agreement. If they want to be able to receive bonus payments, sign ACHN Participation Agreement

40.14.8 Comprehensiveness / Duration of Referral

The comprehensiveness and duration of the referral is determined by the PCP or ACHN Entity and the specialist. 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 specialist decides that the recipient must be treated by another consulting specialist, the first consulting specialist must contact the PCP for approval and authorization to further refer the patient, unless such approval has already been **indicated on the referral form**. The second specialist should then use the PCP's NPI when billing. This same procedure should be followed for **any** successive referrals.

The Physician's NPI number on the Referral Form (Form 362) can be the NPI of the original referring PCP or the NPI of the original referring group.

A pharmacist does not have to contact the PCP 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.

40.14.9 EPSDT Screening Referrals

It is not necessary to redo EPSDT screening referrals on the PCP Referral form (Form 362). If the original screener is not the PCP, then the PCP must either sign on the original PCP referral form (anywhere is acceptable) or

issue a written PCP referral. Referrals can be for duration of up to 12 months for EPSDT referred services. Referrals from a previous PCP may be honored for a 6-month time frame. Please refer to the Appendix A of the Medicaid Provider Manual for further information on EPSDT.

40.15 Override Requests

In extenuating circumstances, on a case-by-case basis, and after thorough review, Medicaid may determine that a referral override may be prudent in some situations. There may also be instances where a BMI cannot be determined (e.g. wheelchair bound recipients). In these cases, providers may request a BMI override using the **PCP Override Request form** to obtain payment. A copy of the **PCP Override Request form** is in Appendix E of the Medicaid Provider Manual. An Override Request Form and a clean Red Drop Ink claim form (CMS Form 1450 (UB-04) or CMS Form 1500) must be submitted to the Network Provider Assistance Unit by mail within 90 days of the date of service. CMS Form 1450 (UB-04) or CMS Form 1500 must be an original and must be signed or the override request will not be approved and returned to the provider. Requests will be evaluated within 60 days of receipt. Overrides will not be approved for well visits.

The override request must be mailed to:

**Alabama Medicaid Agency
Network Provider Assistance Unit
501 Dexter Avenue
P.O. Box 5624
Montgomery, AL 36103-5624**

NOTE:

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

40.16 Reimbursements and Payments to PCP Groups

PCP Groups are eligible to earn higher payments for 15 Evaluation and Management (E&M) codes if they participate with the ACHNs. This higher payment is called the ACHN Participation Rate and includes the following E&M codes: 99201-99205, 99211-99215, and 99241-99245. Nurse Practitioners and Physician Assistants who are enrolled in the PCP Group will receive 80% of the physician rate for these E&M codes.

FQHCs and RHCs are excluded from this payment as they receive encounter rates.

All PCPs (including FQHCs and RHCs) participating with the ACHN will initially qualify to receive Bonus Payments for meeting Quality, Cost Effectiveness, and Patient Centered Medical Home (PCMH) recognition.

Definitions for Different Rates PCPs may earn:

Fee-For-Service Rates: This is the base fee-for-service rate a physician will receive for E&M codes if he/she chooses not to participate with the ACHN.

BUMP Rates: PCPs must qualify for the BUMP rates as described in the link below. Follow the same attestation process as currently exists.

https://medicaid.alabama.gov/documents/1.0_ALERTS/1.0_ALERT_Bump_9-23-16.pdf

Participation Rates: Participation Rates are higher than BUMP rates and will be paid to providers that actively participate with the ACHN (refer to section 40.5). FQHCs and RHCs will not receive these rates, however, but will continue to receive encounter rates.

Bonus Payments: These payments will be made to all participating providers (including FQHCs and RHCs) during the start-up phase of the program and will be based on the attribution of recipients to providers (refer to section 40.19). After the start-up phase, bonuses will be based on performance. Nurse Practitioners, Physician Assistants, and Nurse Midwives will receive 80% of the physician rate for these Bonus Payments. These Bonus Payments also apply to FQHCs and RHCs.

NOTE:

Beginning January 2020, bonus payments will be made on the second checkwrite of the 1st month of the quarter (January, April, July, and October)

Payment Types and Payment Cycles are described in the table below:

Type of Payment	When Paid
Fee-For-Service	Every checkwrite
ACHN Participation Rate	Every checkwrite
Bonus Payment	The second checkwrite of the first month of the quarter.
BUMP Payments	Every checkwrite

The table below shows four different scenarios for PCP Group Payments:

Alabama Medicaid Agency ACHN Primary Care Physician Payment Chart				
Primary Care Physician Scenarios	Base FFS Rates	Bump Rates	Participation Rates	Bonus Payments
PCP Scenario 1: PCPs not eligible for Bump Rates & not participating with ACHN	✓	X	X	X
PCP Scenario 2: PCPs not eligible for Bump Rates & participating with ACHN	✓	X	✓	✓
PCP Scenario 3: PCPs eligible for Bump Rates & not participating with ACHN	X	✓	X	X
PCP Scenario 4: PCPs eligible for Bump Rates & participating with ACHN	X	✓	✓	✓

The table below further describes the four different PCP Group payment scenarios listed above:

EXAMPLE
Participation Rate (PR) = Enhanced Rates for fifteen E & M codes
PCP Scenario 1 Example: Receive only Base FFS Rates for all codes, including the fifteen PR codes
PCP Scenario 2 Example: Receive PR for the fifteen E&M codes, FFS Rates for all other codes, and Bonus Payments
PCP Scenario 3 Example: Receive Bump Rates only (no Participation Rates or Bonus Payments)
PCP Scenario 4 Example: Receive PR for the fifteen E & M codes, Bump Rates for all other codes, and Bonus Payments

BUMP Rates vs. ACHN Participation Rates are described in the table below:

BUMP Rates vs. Participation Rates				
Procedure	Procedure Description	BUMP Rate	ACHN Participation Rate	Amount Increase
99201	OFFICE/OUTPATIENT VISIT NEW	\$40.04	\$42.00	\$1.96
99202	OFFICE/OUTPATIENT VISIT NEW	\$69.27	\$73.00	\$3.73
99203	OFFICE/OUTPATIENT VISIT NEW	\$100.52	\$107.00	\$6.48
99204	OFFICE/OUTPATIENT VISIT NEW	\$155.25	\$166.00	\$10.75
99205	OFFICE/OUTPATIENT VISIT NEW	\$194.18	\$210.00	\$15.82
99211	OFFICE/OUTPATIENT VISIT EST	\$18.46	\$19.00	\$0.54
99212	OFFICE/OUTPATIENT VISIT EST	\$40.36	\$41.00	\$0.64
99213	OFFICE/OUTPATIENT VISIT EST	\$68.17	\$72.00	\$3.83
99214	OFFICE/OUTPATIENT VISIT EST	\$100.91	\$108.00	\$7.09
99215	OFFICE/OUTPATIENT VISIT EST	\$135.59	\$146.00	\$10.41
99241	OFFICE CONSULTATION	\$45.45	\$46.00	\$0.55
99242	OFFICE CONSULTATION	\$85.87	\$88.00	\$2.13
99243	OFFICE CONSULTATION	\$117.58	\$122.00	\$4.42
99244	OFFICE CONSULTATION	\$175.38	\$184.00	\$8.62
99245	OFFICE CONSULTATION	\$214.62	\$226.00	\$11.38

40.17 Urban/Rural Counties (for Providers)

A map showing urban and rural counties for providers may be accessed on the Medicaid website at: www.medicaid.alabama.gov, then select the ACHN tab, ACHN Providers, Medicaid’s Designated Urban and Rural Map.

40.18 Agency Monitoring

Active Participation requirements will be monitored monthly by the Agency and the ACHN. The Agency will remove a PCP or PCP Group from the ACHN for not meeting requirements. Before a PCP Group is removed from ACHN participation, the Agency will confirm with the ACHN and the PCP Group that the Group did not meet the requirements.

40.19 Attribution

Under the ACHN Program, Medicaid recipients will be attributed to physicians based on historical claims data utilization. **To determine the provider types that are identified as PCPs, refer to section 40.4: PCP Determination.** Reference Rule No. 560-X-37-.09, “Attribution under the Alabama Coordinated Health Network Program.” Attribution is the process that will be used to associate a Medicaid recipient to the PCP Group that provides primary care to that recipient. Attribution is a critical factor in determining distribution of Bonus

Payments among eligible providers. On a quarterly basis, the Medicaid Agency will determine attribution for each Medicaid recipient under the ACHN Program in accordance with the following process:

- The Medicaid Agency will review the previous two-year history of face-to-face provider visit utilization for each Medicaid recipient. Utilization will consider both preventive visits and regular office visits.
- Points will only be awarded for claims that are in a paid status before the end of the attribution run period.
- If a specialist group has the highest number of points, then the specialist group will be attributed the Medicaid recipient; however, a specialist group shall not be eligible to receive the bonus payments described above.
- The Medicaid Agency will review the previous 12-month history of filled prescriptions for chronic care conditions for each Medicaid recipient.
- The point values described below associated with the visits and prescriptions will be assigned to the individual doctor that performed the service. The individual PCP scores will be combined to form the PCP Group's total point score for each patient.
- PCP Groups will receive points based on the number of preventive visits (CPT 99381-99387, 99391-99397) and regular office visits (CPT 99201-99205, 99211-99215) conducted by the PCP Group. Points will be awarded as follows:

	Type of Visit	0-6 Months Ago	6-12 Months Ago	12-18 Months Ago	18-24 Months Ago
PCP	Standard	4	4	2	2
	Preventative	8	4	4	2
Non-PCP Specialist	Standard	2	2	1	1
	Preventative	4	2	2	1

- PCP Groups will receive points based on the number of prescriptions filled for chronic care conditions. For the purposes of this rule, prescriptions for chronic care conditions shall mean more than one prescription filled for a chronic condition (e.g., asthma) and must correspond to an office visit from the prescribing provider within the previous two (2) years.
- The PCP Group with the highest number of points will have the Medicaid recipient attributed to that PCP Group. The Medicaid recipient must have met criteria for the ACHN Program for three (3) out of the previous twenty-four (24) months to be attributed.

40.19.1 Attribution Report

A listing of attributed recipients will be provided to PCP Groups. The report is produced quarterly after the attribution process is complete. The report will list new attributions, continuing attributions and terminated attributions. The report is available to PCPs from the Alabama Medicaid Interactive Services Web Site (web portal).

The following table lists the timeframe in which attribution reports will be available via the secure web portal:

Attribution Period	Attribution Run Month	Attribution Reports Available
January 1, 2021 – March 31, 2021	November 2020	First week of December 2020
April 1, 2021 – June 30, 2021	February 2021	First week of March 2021
July 1, 2021 – September 30, 2021	May 2021	First week of June 2021
October 1, 2021 – December 31, 2021	August 2021	First week of September 2021

Each quarter, the PCP Group can obtain a listing of pending recipients (new patients) that have been attributed to them, all continuing enrollees that are attributed to the PCP, and those enrollees that have been removed from the PCP's attribution. The listing will include the recipient's demographic information, Medicaid number, aid category, and county code. The enrollee status will be noted at the top of each page as pending, continuing or terminated.

- Pending Attributions– enrollees that are new to your attribution.
- Continuing Attributions – enrollees that have been previously attributed and continue to be attributed to the PCP.
- Terminated Attributions – enrollees that have been deleted from the PCP's attribution. A termination code will be listed on the report indicating the reason the recipient was terminated from the provider's attribution list. Below is the code legend that will be listed on the last sheet of the attribution report explaining the recipient's reason for termination.

Termination Reason Code	Description
1	RECIPIENT HAS BEEN ATTRIBUTED TO A NEW PROVIDER
2	RECIPIENT NO LONGER ASSIGNED TO AN ACHN NETWORK
3	RECIPIENT NOT MET MONTHS OF ELIGIBILITY REQUIRED
4	RECIPIENT HAD NO CLAIMS IN THE EVALUATION PERIOD
5	RECIPIENT HAS BEEN REKEYED. THIS ID IS NO LONGER ACTIVE

40.19.2 **Reconsideration of Attribution**

A PCP Group may request the attribution calculation for any Medicaid recipient who has received care from the group. If a PCP Group believes the Medicaid Agency has not properly attributed one or more Medicaid recipients to the PCP Group, it may request the Medicaid Agency reconsider its attribution calculation.

- A request for reconsideration must be submitted to the Medicaid Agency in writing and within seven business days of the quarterly attribution notification. The written request for reconsideration must contain:
 - the period of attribution

- the name(s) of the Medicaid recipient(s) that the PCP Group believes was/were not properly attributed
- supporting information and/or documentation demonstrating that the Medicaid Agency either failed to or improperly considered information which had a material impact on the result of the attribution
- The PCP Group that has been attributed the Medicaid recipient(s) subject to the request for reconsideration shall be notified by the Medicaid Agency of the request and be permitted to submit information for Medicaid Agency consideration within three business days of the notice. If the PCP Group that has been attributed the Medicaid recipients subject to the request for reconsideration does not respond to Medicaid within the three-day time frame—Medicaid will continue the review without additional information from the attributed group.
- The Medicaid Agency will review all relevant information and complete any adjustments to the PCP Group's Medicaid recipient attribution within seven business days of receipt of the request for reconsideration.

Reconsideration requests must be submitted to Travis Houser at travis.houser@medicaid.alabama.gov.

40.20 Quality Assurance Activities

Quality assurance activities and program monitoring will be the responsibility of the Managed Care Operations Division. Monitoring efforts will look at all facets of the program including measuring the PCP against established program goals, determining contract compliance, and focusing on program outcomes – all of which involve both administrative and performance measures.

Bonus Payments for the PCP Group will be available if the PCP Group:

- Enters into a Participation Agreement with an ACHN
- Actively participates with an ACHN
- Meets the criteria established by the Agency for quality
- Meets the criteria established by the Agency for cost effectiveness
- Achieves (or working towards) Patient Centered Medical Home (PCMH) Recognition.

Bonus Payments for Quality, Cost Effectiveness, and PCMH Recognition

This is a Bonus pool in the amount of \$15 million annually to fund three (3) Bonus payments for eligible Participating PCP Groups. The Bonus Payment pool is allotted as follows:

- 50% for Quality
- 45% for Cost Effectiveness
- 5% for PCMH Recognition

The first quarterly payment will be made on the first checkwrite in November 2019. Subsequent payments will be made on a quarterly basis beginning in January 2020. Beginning January 2020, the quarterly bonus payments will be made on the second checkwrite of the 1st month of the quarter.

Beginning with the January 22, 2021 checkwrite, the Alabama Medicaid Agency will set aside funds from the annual Alabama Coordinated Health Network (ACHN) bonus payment pool. The reserved funds will help assist with unforeseen situations

that would cause the Agency to recoup and redistribute the bonus pool. The Agency will reserve a total of \$400,000 from the annual \$15 million bonus pool. This is equivalent to a reserve of \$100,000 per quarter. If a primary care physician (PCP) group is inadvertently omitted from the bonus payment distribution, the Agency will use the reserve funds to pay the PCP group(s). In addition, if funds are recouped from a PCP group, the recouped amount will be added to the reserve funds. During the last quarter of the fiscal year, the Agency will distribute any remaining reserve funds to actively participating ACHN PCP groups. For more information about the reserve funds, refer to the Changes to the Alabama Coordinated Health Network (ACHN) Bonus Payment Distribution ALERT on the Medicaid website.
Medicaid ALERTs: <https://medicaid.alabama.gov/alerts.aspx>

Quality Bonus Payments: PCP Groups will be eligible for a Bonus Payment if the PCP Group meets the requirements described below:

- For the first seven (7) quarters of the program, all practice groups will automatically receive a Quality Bonus Payment that is based solely on the number of attributed patients
- Beginning October 2021, the Group must achieve annual Bonus benchmarks determined by the Medicaid Agency
- Benchmarks are statewide, updated annually, and will be posted to the Agency's website at www.medicicaid.alabama.gov (Click the ACHN tab/Provider).

PCP Quality Measures are listed below:

- Well-child visits for children, ages 3-6
- Adolescent well care visits
- Immunization status—Child
- Immunization status—Adolescent
- Antidepressant medication management
- HbA1c test for diabetic patients
- Follow-up after ER visit for alcohol or other drugs
- Chlamydia Screening in Women

Cost Effectiveness Bonus Payments: For at least five (5) quarters, ACHN participating PCP groups will receive a Cost Effectiveness Bonus Payment based on the number of Medicaid recipients attributed to the PCP group for the prior quarterly period.

After the first four (4) quarters, PCP Groups will be eligible for a Bonus payment if the PCP group meets or exceeds the Cost Effectiveness criteria established by the Agency. Payments will be distributed to each PCP group that has met criteria. The Cost Effectiveness Bonus calculation that will begin with the Winter 2021, payment is described below:

- Compares a 12-month per member per month (PMPM) to a risk-adjusted expected PMPM based on the costs of similar PCP groups that treat Medicaid recipients
- Groups ranked by an efficiency score that is derived from actual PMPM versus the expected PMPM

- Bonus payment is paid for PCP groups at or below the median efficiency score (i.e., more efficient)
- Calculation occurs three months after the previous twelve (12) month's performance has been derived. For example, the quarterly payments made in January 2021 will be based on the actual Cost Effectiveness calculated for the period between October 1, 2019, and September 30, 2020, providing three months of claims payment completion. Likewise, the quarterly payments made in April 2021, will be based on the actual cost effectiveness calculated for the period between January 1, 2020 and December 31, 2020, to allow for three months of claims payment completion.

The Cost Effectiveness calculation includes a PMPM calculation for the ACHN population. The Cost Effectiveness calculation excludes the most recent three (3) months of data, hospital access payments, entity case management costs, other Bonus Payments in the waiver, and drug rebates.

Patient Centered Medical Home (PCMH) Recognition Bonus Payments:

The purpose of the PCMH Recognition Bonus payment is to incentivize providers to attain PCMH recognition ensuring Medicaid recipients are receiving care through a nationally recognized medical home model. Participating PCP groups can obtain PCMH recognition or certification through nationally recognized entities such as National Committee for Quality Assurance (NCQA), the Compliance Team, or the Joint Commission among others. The PCP group's PCMH Recognition certification of achievement and/or supporting documentation (proof) as adequate progress towards achievement must be in an active status on the last day in September of the (current) fiscal year in order to receive approval for the next fiscal year. For example, the quarterly payments made in October 2020, January 2021, April 2021, and July 2021 will be based on the PCP group's attestation of their achievement of recognition or certification as of the last business day in September 2020.

Details from NCQA can be found at:

https://www.ncqa.org/programs/health-care-providers-practices/patient-centered-medical-home-pcmh/?utm_source=ncqa&utm_medium=homepage-link&utm_campaign=pcmh&utm_content=left.

Details from the Compliance Team can be found at:

<https://thecomplianceteam.org/our-accreditation-programs/patient-centered-medical-home-pcmh/>

Details from the Joint Commission can be found

at: https://www.jointcommission.org/certification/primary_care_medical_home_certification.aspx

Effective for fiscal year 2022 (October 1, 2021- September 30, 2022), **All** PCP groups will be required to attest to Medicaid no later than October 1st **annually**. All PCP groups will be required to submit the PCMH Attestation Form, regardless of which PCMH certifying agency the provider used to become PCMH recognized.

The PCMH Recognition bonus payment attestation and proof of (achievement or progress towards achievement) are due to Medicaid **annually, no later than the deadline date/time of October 1, by 5:00 P.M. (CST)**.

PCMH Recognition (**adequate progress**) towards achievement is defined as follows:

- a. National Committee for Quality Assurance (NCQA)- PCP groups must have completed at least 1 (one) check-in and met 1 or more Cores within the qualifying timeline for the upcoming fiscal year. Core met proof of supporting documentation must show continued progress until full PCMH Recognition has been obtained. Providers can send a screen print of the 'transforming' page in their dashboard from the NCQA website.
- b. The Compliance Team- PCP groups must provide proof that progress has been made on their Quarterly PCMH Quality Reporting. Progress is defined as improvement in numbers as the months proceed. A blank PCMH Quality Reporting is unacceptable. The PCP group must have completed at least one (1) quarter with said entity and show continued progress towards PCMH Recognition accreditation.
- c. The Joint Commission- PCP groups must provide proof that they have reached the 'Prepare for Survey' stage and/or beyond of the PCMH process. Additionally, at least 1 (one) of the tools within 'Prepare for Survey' must have been utilized or accessed to demonstrate progress.

~~Deleted: PCP Groups that...Recognition bonus payment.~~

PCMH achievement or progress toward PCMH achievement will be required from all PCP Groups that would like to receive a bonus payment for PCMH recognition beginning in the first quarter of FY 2021.

Added: NCQA, the Joint Commission, the Compliance Team
Deleted: JCAHO

PCP Groups that received or making progress towards PCMH Recognition through NCQA, the Joint Commission, the Compliance Team or another certifying entity must submit an Attestation Form and proof of their PCMH Recognition certification to the Medicaid Agency.

~~Deleted: For those PCP...during the previous year.~~

For those PCP Groups who are working toward PCMH Recognition with a nationally recognized entity, progress toward completion of PCMH Recognition must be shown. The Agency will determine the appropriate level of progress to receive the 5% bonus payment. A screen print of this progress must be attached to the attestation form and can be obtained from the nationally recognized entity. The Agency will review the Attestation Form with the required attachments and will process based on established guidelines. If the Agency disapproves the submitted Attestation Form and attachments, a formal letter will be mailed to the PCP Group explaining the reason(s) for the disapproval.

Added: toward PCMH Recognition
Deleted: ~~other than NCQA...must show~~
Added: must be shown.

Send the completed PCMH Attestation Form and its supporting documentation (proof) by mail to:

Alabama Medicaid Agency
Network Provider Assistance Unit
501 Dexter Avenue
P.O. Box 5624
Montgomery, Alabama 36103-5624

- Blind/Disabled children and adults;
- Aged and related populations;
- Children under age 19;
- Parents or other caretaker relatives (POCR);
- Foster children;
- Former Foster Care;
- Breast and Cervical Cancer; and
- American Indians (note: may opt-out at any time).

Medicaid recipients listed in the below categories of Medicaid eligibility / in the following circumstances are **excluded from participation in ACHN**:

- Medicaid Dual Eligibles (covered by Medicare & Medicaid);
- Long-term institutional care;
- Home and Community-Based Services Waiver;
- Children in the custody of the Department of Youth Services;
- Inmates and people living in Institutions for Mental Diseases (IMDs);
- Aged, blind or disabled individuals receiving only optional state supplements;
- Individuals participating in the Program of All-Inclusive Care for the Elderly (PACE);
- Individuals utilizing hospice services;
- Individuals receiving Refugee Medical Assistance;
- Individuals with other commercial managed care insurance or participating in the Health Insurance Premium Payment (HIPP) program; and
- Individuals with limited or no Medicaid coverage (e.g., some non-citizens only eligible for emergency services, or individuals receiving short-term hospital presumptive eligibility).

40.23 Lock-in Recipients

The Alabama Medicaid Agency closely monitors program usage to identify recipients who may be potentially overusing or misusing Medicaid services and benefits. For those identified recipients, qualified Alabama Medicaid staff performs medical desk reviews to determine overuse and/or misuse of services. If the review indicates overuse and/or misuse of services, the recipient may be locked in to one physician and/or one pharmacy. Additional limitations may be placed on certain medications such as controlled drugs and/or other habit-forming drugs.

Recipients who are placed on lock-in status are notified by letter of the pending restriction. They are asked to contact the Recipient Review Unit or the Clinical Services and Support Division at the Alabama Medicaid Agency with the names of their chosen physician and/or pharmacy. The physician and pharmacy are contacted by the Recipient Review Unit or the Clinical Services and Support Division to determine if they will agree to serve as primary care physician/designated pharmacy while the recipient is restricted.

40.23.1 **Referring Recipients with Lock-in Status**

Physicians who serve as a restricted recipient's lock-in provider should use the Alabama Medicaid Agency Referral Form (Form 362) when referring the restricted recipient to another physician. Please note that this is the same form that is used for Alabama Coordinated Health Network (ACHN) Primary Care Provider (PCP) referrals. The referral may cover one visit or multiple visits so long as those visits are part of the plan of care and are medically necessary. No referral can last more than one year. This form can be obtained by accessing Medicaid's website.

NOTE:

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

40.24 **Eligibility Verification**

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

- The Provider Electronic Solution (PES) is a point of service device or PC based software system, which accesses recipient information.
- The Automated Voice Response System may be accessed by dialing 1 (800) 727-7848 using a touch-tone telephone. This is an automated telephone system available approximately 24 hours a day, 7 days a week unless down for maintenance.
- The Web User Guide provides instructions for performing recipient eligibility verification via the web portal. Instructions for accessing and login are also included in the guide. The Web Portal verification system will provide contact information for the recipient's attributed PCP. Providers can access the Web User Guide at the following link:
<https://www.medicaid.alabamaservices.org/ALPortal>.

40.25 **Emergency Services**

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

40.26 **Certified Emergency Services**

Hospitals and physicians who provide "certified emergency" services in the Emergency Room (ER) are not required to have a referral from the PCP. Please note that follow-up care should not be certified as an emergency and in some cases may require PCP referral (i.e. physical therapy, suture removal, rechecks, etc.).

In order for the claim not to require a PCP 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 PCP referral.

The Agency stresses the importance of coordinating with the PCPs and ACHNs regarding the care of Medicaid recipients in order to preserve the continuity of care and the "medical home" concept.

40.27 Immunizations

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

Providers should be aware that the parent/guardian of children will be looking to the PCP for immunizations and/or documentation of immunizations, especially in the months prior to school starting. PCPs should be prepared to immunize these children or make arrangements to get appropriate information from the immunizing provider to meet the school rush. **ALL PCPs SHOULD MAKE EVERY EFFORT TO WORK WITH OTHER PROVIDERS IN THE COMMUNITY TO ENSURE THAT ALL CHILDREN ARE FULLY AND APPROPRIATELY IMMUNIZED.**

40.28 Program Enhancements

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

40.28.1 *In-Home Remote Patient Monitoring*

Patients with a diagnosis of Diabetes, Hypertension, and Congestive Heart Failure (CHF) are eligible for enrollment in this in-home remote patient monitoring program. The goal of the program is to decrease exacerbation episodes, emergent care visits, hospital admissions, and medical costs.

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

To refer a patient to the In-Home Remote Patient 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

40.29 Obtaining Educational Materials

Some materials that are available for download from the website include:

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

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

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

NOTE:

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

40.30 Medicaid Forms

The following forms can be found in Appendix E and/or on the Medicaid website www.medicaid.alabama.gov under Resources/Forms Library/ACHN/PCP Forms:

Form ID	Form Description
Form 172	EPSDT Child Health Medical Record
Form 284	To enroll children of Medicaid-eligible mothers (including SSI mothers) from birth to first birthday - with instructions
Form 362	Alabama Medicaid Referral Form
Form 362-I	Instructions for completing “The Alabama Medicaid Referral Form 362
Form 391	PCP Override Request Form
ACHN Disenrollment Request Form	Group/PCP Disenrollment Requests
Immunization Documentation	Link to ADPH website regarding Pediatric, Adolescent and Adult Immunization Records

40.31 PCP Billing Instructions

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

To bill for a specialty service that requires a PCP referral, the billing provider must have a valid signed referral form in the recipient’s medical record. This form should contain the PCP’s number to use for billing.

40.32 Delivering Healthcare Professionals (DHCPs)

40.32.1 Enrollment

Gainwell enrolls providers who contract with Alabama Medicaid as a Delivering Healthcare Professional (DHCP). A copy of this contract will be required with the request to enroll as a DHCP.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

Providers who contract with Alabama Medicaid as a DHCP are added to the Medicaid system with the National Provider Identifiers provided at the time application is made. Appropriate provider specialty codes are assigned to enable the provider to submit requests and receive reimbursements for Maternity Care related claims.

NOTE:

The 10-digit NPI is required when filing a claim.

ACHN DHCP Agreement: All DHCPs, including Maternal Fetal Medicine (MFM) and telemedicine providers, must sign one additional agreement beyond their Medicaid Enrollment. The DHCP must sign an agreement with an ACHN in order to receive reimbursement of maternity services and bonus payments. On a monthly basis, ACHNs will notify the Agency of all executed ACHN DHCP agreements. DHCPs and ACHNs must ensure that the Medicaid Group Billing ID, NPI, Medicaid ID, and name listed on the DHCP agreement is correct and consistent with what the Agency has on the provider's Medicaid file. The provider's file must also be in an active status with the Medicaid Agency. All information submitted must be based on the group level unless the DHCP is set up as an individual practice. If the information is not correct or consistent, the agreement will not be added to the provider's Medicaid file. In the absence of this agreement, DHCPs will not be eligible for reimbursement for maternity services and will not receive bonus payments for performing first trimester and post-partum visits. If all information communicated to the Agency is correct, the enrollment effective date for the ACHN DHCP Agreement will be the first day of the following month. Contact the ACHN you intend to participate with to inquire about submission deadlines for the DHCP Agreement.

To obtain the DHCP Group Agreement with the ACHN, email the ACHN Regional contact listed in section 40.1.

NOTE:

To receive reimbursement for maternity related services, all Maternal Fetal Medicine (MFM) and telemedicine providers must sign one additional

agreement beyond their Medicaid Enrollment. The DHCP agreement must be signed with one of the ACHNs.

40.33 Telemedicine Providers

Telemedicine providers who render maternity related services are required to sign a DHCP agreement with one of the ACHNs to receive reimbursement from Medicaid. Refer to Chapter 28 of the Provider Billing Manual to determine further requirements and procedure codes for telemedicine services.

Beginning July 8, 2020, Medicaid will allow physicians enrolled with the specialties OB/GYN (specialty type 328) and telemedicine (specialty type 931) to be reimbursed for maternity services with a referral from either an ACHN or the referring DHCP. The NPI of the ACHN, the DHCP, or the referring DHCP's group must be on the claim for reimbursement. Refer to section 40.43.2 (DHCP Selection Referral Number) for more detailed billing information.

Telemedicine providers who render maternity-related services are required to sign a Non-Delivering Telemedicine DHCP Participation agreement with at least one of the ACHNs in order to receive reimbursement from Medicaid. Refer to Chapter 28 of the Provider Billing Manual to determine further requirements and procedure codes allowed for telemedicine services.

40.34 ACHN Contact Information (for DHCPs)

Refer to Section 40.1: ACHN Overview for ACHN contact information for DHCPs.

40.35 DHCPs Benefits and Limitations

This section describes program-specific benefits and limitations. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations. Refer to Chapter 7, Understanding Your Rights and Responsibilities as a Provider, for general criteria on Medical Necessity/ Medically Necessary Care.

40.36 Eligible Recipients

Refer to Section 40.22 for a listing of eligible recipients.

NOTE:

Medicaid SOBRA (Pregnant Women) recipients, who were once eligible for pregnancy-related services ONLY may receive full Medicaid benefits throughout pregnancy and post-partum, whether the services were pregnancy related or not. A Primary Care Physician (PCP) referral is NOT required to receive non-pregnancy related services.

Claims that are pregnancy related will require a pregnancy related diagnosis code or a postpartum diagnosis code. Co-pays may be applied for services that are non-pregnancy related. A recipient's age, health care requirements, and place of residence may further define his or her eligibility for Medicaid covered services. For this reason, it is very important that the providers verify recipient eligibility and ensure they understand all aspects of the eligibility response.

Eligibility responses have been changed to reflect the correct coverage for these women.

Refer to Chapter 4, Obtaining Prior Authorization (PA) for PA requirements.

Recipients are notified at the time of Medicaid application of the requirement to participate in the ACHN Program.

40.37 Recipient County Moves and Changes

Maternity recipients must receive a DHCP Selection Referral number from their assigned ACHN for maternity related services. In some instances, the maternity recipient may have a different county listed on their eligibility verification. In these situations, the maternity recipient must contact Medicaid to update their address and county. The recipient can update their address and county by calling the recipient call center, complete an update form (Form 295), contact their local caseworker, or use their My Medicaid online account. After the update has been requested, the address and county will update within 24 business hours. However, the ACHN assignment will not change until the following month (if completed on or before the 27th of the month). Until the ACHN assignment is updated, the DHCP must work with the ACHN that the recipient is currently assigned to for referrals.

40.38 Hospital Presumptive Eligibility

Hospital Presumptive Eligibility (HPE) is temporary Medicaid coverage for up to 60 days. Coverage begins the first day of the month and ends the last day of the following month if the person has not applied for regular Medicaid within the 60 days. The HPE application is approved by the HPE Determiner affiliated with a Qualified Hospital that has elected to participate. If a recipient is approved as pregnancy only, services are limited to ambulatory prenatal and pregnancy-related care only (inpatient expenses are not covered). To access the Patient HPE Application and the HPE Provider Agreement use the following link:

http://medicaid.alabama.gov/content/9.0_Resources/9.4_Forms_Library/9.4.7_Hospital_Forms.aspx

40.39 Covered Services

All services provided by the DHCP will be billed fee for service.

40.39.1 Antepartum Care

Antepartum care includes the following usual prenatal services:

- Initial visit at the time pregnancy is diagnosed
- Initial and subsequent histories
- Maternity counseling
- Risk assessments
- Physical exams
- Recording of weight
- Blood pressure recordings
- Fetal heart tones
- Lab work appropriate to the level of care including hematocrit and chemical urinalysis

40.39.2 Delivery

Delivery includes vaginal delivery, with or without episiotomy, with or without forceps or cesarean section delivery. More than one fee **may not** be billed for a multiple birth delivery. Delivery includes, but is not limited to, professional services, such as physician's services and anesthesiology. Any non-routine newborn care must be billed under the baby's Medicaid number. Please refer to Chapter 28 for charges that are billable fee-for-service by physicians.

40.39.3 Hospitalization

Hospitalization includes delivery as well as any pregnancy-related hospitalizations that occur in the antepartum period or postpartum period. Hospitalization includes all charges that are normally submitted on the uniform billing claim form (UB-04), which includes but is not limited to the following:

- Labor
- Delivery or operating room
- Room and board including well baby nursery days
- Drugs, supplies, and lab/radiology services obtained during
- hospitalization

NOTE:

Physician sterilization charges may be billed fee-for-service.

All outpatient hospital services associated with a pregnancy related condition are to be billed as fee for service by the Provider of service utilizing the most appropriate CPT code. **A pregnancy diagnosis code, primary or secondary, must be used when billing maternity care services.**

40.39.4 Postpartum Care

Postpartum care includes office visits, home visits, and in-hospital visits following delivery for routine care through the end of the month of the 60-day postpartum period. The postpartum exam should be accomplished 21 to 56 days after delivery.

40.39.5 Care Coordination Services

The ACHN care coordinator arranges a coordinated system of obstetrical care for pregnant women based on specific guidelines for care coordination services. The care coordination services provided by the ACHN for a maternity recipient are listed below:

- Eligibility assistance
- First Face-to-Face encounter
- Face-to-Face follow-up encounter (two encounters allowed if high risk)
- Inpatient Face-to-Face delivery encounter
- In home Face-to-Face postpartum encounter (for high risk recipients)

40.39.6 Assistant Surgeon Fees

The assistant surgeon fees for cesarean (C-section) deliveries are to be billed fee for service.

40.39.7 Anesthesia Services

Anesthesia services include anesthesia services performed by an anesthesiologist or the delivering physician that are not medically contraindicated.

40.39.8 Ultrasounds

DHCPs must perform medically necessary ultrasounds and submit fee for service claims to Gainwell for payment. The details regarding ultrasounds are found in the Provider Billing Manual Chapter 28.

40.39.9 Other Billable Services

Services provided outside the scope of the global fee that may be billed separately are listed below:

Separately Billable Service	Description
Drugs	Family planning or general drugs (for example, oral contraceptives or iron pills) prescribed by a provider with a written prescription to be filled later may be billed on a fee-for-service basis. In addition, women on Plan First have the option of obtaining oral contraceptives, the contraceptive ring, or the contraceptive patch, with a prescription from a private provider, at a Medicaid-enrolled community/outpatient pharmacy. Injections administered by the physician or outpatient facility can be billed on a fee-for-service basis (for example, Rhogam or Iron). Smoking cessation products for pregnant women will be covered after prior authorization through the Pharmacy Administrative Services contractor. Refer to Appendix Q Tobacco Cessation for additional information. The recipient must be enrolled and receiving counseling services through the Alabama Department of Public Health Quitline. Approval will be granted up to 3 months at a time.
Lab Services	All lab services except hemoglobin, hematocrit, and chemical urinalysis.
Radiology	All radiology services are outside of the global fee unless performed during an inpatient stay or for ultrasounds and non-stress tests. The professional component for radiology services is a component of the primary contractor global fee and should be billed separately to the primary contractor with the exception of teaching hospitals.
Dental	Dental services are covered for recipients under 21 years of age.
Physician	Physician fees for family planning procedures (for example, sterilization), and genetic counseling. Claims for circumcision, standby and infant resuscitation may be billed under the mother's name and number on a fee-for-service basis.
Family Planning Services	Appropriate Family planning services with family planning procedure code or indicator. Eligible recipients will continue to have the option of receiving family planning services from the Alabama Department of Public Health or a Federally qualified Health Center. All family planning services must meet program guidelines and eligibility criteria.

Home Visit (99347-FP)	<p>The home visit is a brief evaluation by a medical professional in the home of an established recipient and is for the purpose of providing contraceptive counseling (using the PT+3 teaching method) and administration/issuance of contraceptive supplies. The home visit is for postpartum women during the 60-day postpartum period and usually occurs within 7-14 days after delivery. A home visit is limited to one per 60-day postpartum period and usually occurs within 7-14 days after delivery. A home visit is not a covered service for recipients with Plan First eligibility and can only be provided as a family planning service by Medicaid eligible family planning providers to eligible recipients.</p> <p>To qualify for reimbursement for the home visit:</p> <ul style="list-style-type: none"> • Medical professionals who are licensed to administer medications such as oral contraceptives or to give injections must provide the home visit. • The home visit must include: brief medical histories: family, medical, contraceptive, and OB/GYN, blood pressure and weight check, contraceptive education and counseling using the PT+3 teaching method assuring that the recipient: <ul style="list-style-type: none"> – understands how to use the method selected, – how to manage side effects/adverse reactions, – when/whom to contact in case of adverse reactions, and the importance of follow-up. – scheduling of a follow-up visit in the clinic if needed – issuance or prescription of contraceptive supplies as appropriate. <p>The recipient must give her signed consent for this visit.</p>
Extended Family Planning Counseling Visit (99212-FP)	<p>The extended family planning counseling visit is a separate and distinct service consisting of a minimum of 10 face-to-face minutes of extended contraceptive counseling using the PT+3 teaching method. The extended family planning counseling visit is for postpartum women during the 60-day postpartum period and is performed in conjunction with the 6-week postpartum visit in the office/clinic setting. An extended family planning counseling is limited to once during the 60-day post-partum period, and is not available for women who have undergone a sterilization procedure or Plan First eligible recipients on the Plan First Program.</p> <p>The counseling services are those provided above and beyond the routine contraceptive counseling that is included in the postpartum visit. The purpose of this additional counseling time is to take full advantage of the window of opportunity that occurs just after delivery when the physical need for pregnancy delay is at a peak.</p> <p>An Extended Family Planning Counseling Visit is not covered for Plan First recipients and can only be provided as a family planning service by eligible family planning providers to eligible recipients.</p> <p>The following services are required:</p> <ul style="list-style-type: none"> • Contraceptive counseling and education • STD/HIV risk screening and counseling, and • Issuance of contraceptive supplies. <p>NOTE:</p> <p>In the event of a premature delivery or miscarriage, the EDC, "Expected Date of Confinement", must be documented on the claim form in block 19 in order to be reimbursed for procedure code 99212-FP.</p> <p>All visits must be documented in the recipient's chart and reflective of the treatment and care provided.</p>

Emergency Services	Outpatient emergency room services (including the physician component) (claims containing a facility fee charge of 99281, 99282, 99283, 99284, or 99285) and associated physician charges (99281-99288) will be reimbursed separately from the global fee. Access to emergency services will not be restricted by the Maternity Care Program.
Transportation	Transportation as allowed under the Alabama Medicaid State Plan may be billed on a fee-for-service basis.
Mental Health	<p>Screening, Brief Intervention, and Referral to Treatment (SBIRT) are services designed to identify individuals who are at risk for development of substance use disorders, assist individuals in implementing strategies to reduce the potential for development of substance use disorders, and refer individuals who have identified needs for substance abuse treatment to specialized substance abuse treatment providers.</p> <p>Note: The intent of SBIRT is referral for Substance Abuse to include alcohol and drug abuse as smoking cessation is covered in the Maternity Care Program under Care Coordination Services.</p> <p><u>Screening</u>: A full screen, as reimbursable through this benefit, is a structured process used to identify an individual whose current use of alcohol and/or other drugs creates a clearly defined risk for harm in some life dimension. A non-reimbursable pre-screening process must provide documentation of the need for a full screen. The pre-screening process may consist of, as few as, one to two brief questions incorporated into a general health questionnaire; a valid and reliable short screening tool; observations of attending medical personnel; interview and self-report; laboratory results; and/or concerns expressed by significant others.</p> <p>The full screen must be conducted utilizing an authorized, evidence-based screening tool with established reliability and validity in the identification of individuals who are at risk for developing substance use disorders. The tool must also provide enough information to establish an appropriate level of intervention in relation to each individual's identified risk factors. Authorized tools that may be used to conduct the full screen include the following:</p> <ul style="list-style-type: none"> • Alcohol, Smoking, and Substance Involvement Test (ASSIST) • Drug Abuse Screening Test (DAST) • Alcohol Use Disorders Identification Test (AUDIT) • Car, Relax, Alone, Forget, Family or Friends, Trouble (CRAFT) Questionnaire • Problem Oriented Screening Instrument for Teenagers (POSIT) • UNCOPE Substance Abuse Screening <p>Additional tools that conform to the criteria specified above may be utilized to provide the full screen. Prior to use, however, each tool not listed above must be reviewed and authorized for use by the Alabama Medicaid Agency.</p> <p>The full screening process includes the provider's evaluation of the results and an explanation of these results to the individual who has been screened. The provider must clearly explain the level of risk associated with the identified alcohol and/or drug use pattern, and describe the corresponding implications within the context the individual's health and other life dimensions.</p> <p>The provider's response to low risk substance use shall be provided during the screening process as according to the identified needs of the individual. This may include, but is not limited to, the dissemination of material that provides information on the risks associated with drinking and drug use, for example:</p>

	<ul style="list-style-type: none"> • Potential alcohol and drug interactions with medications the individual is taking. • The potential for exacerbation of a health condition with alcohol and drug use. • The potential impact of alcohol or drug use on pregnancy. <p>If the individual has a positive full screen, indicative of a moderate to high risk for a substance use disorder, the provider must be prepared to conduct or obtain brief intervention services during this same visit.</p> <p><u>BRIEF INTERVENTION</u> A brief intervention is an organized encounter that includes, at a minimum, a provider and an individual who has been identified through a full screening process as being at moderate to high risk for development of a substance use disorder. Through the use of motivational strategies with demonstrated effectiveness, the goals of a brief intervention are to increase the individual's awareness and insight regarding current alcohol and/or drug use; to establish acceptance of a need for change; and to support the individual in development and implementation of a plan for change.</p> <p>The brief intervention may consist of a single brief (15 minutes) session or multiple brief sessions dependent upon the unique needs of each individual. Referrals for specialized substance abuse treatment services are provided in conjunction with brief interventions. During any brief intervention, including the first session, the provider must be prepared to make a direct referral to a specialized substance abuse treatment provider for individuals who are at high risk for severe substance use and related consequences. Referrals must be initiated as soon a need for such is established.</p> <p><u>SERVICE UNITS/LIMITS</u> Screening: H0049 Service Unit: Episode Limit: One per pregnancy</p> <p>Providers may bill for time that is spent face-to-face administering an authorized screening tool, discussing the screening results, and providing recommendations for further actions. Providers may not bill for the time during which an individual self-administers a screening tool.</p> <p>Brief Intervention: H0050 Service Unit: 15 minutes Limit: 1/day, 2/pregnancy</p> <p>Providers may bill for time that is spent face-to-face implementing strategies to assist individuals with moderate to high risks for development of substance use disorders in behavior modification that supports risk reduction. Allowable strategies include efforts made by the provider to assist the individual in accessing specialty substance abuse treatment services when there is an identified need for such.</p> <p><u>Restrictions:</u> SBIRT services are not a covered benefit for:</p> <ul style="list-style-type: none"> • Smoking and tobacco abuse. • Individuals who have been diagnosed with a substance use disorder. • Individuals who have had previous and/or are now receiving treatment for a substance use disorder. <p><u>Service Documentation:</u> Documentation of services provided shall incorporate the following:</p>	
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	<ul style="list-style-type: none"> • The need for and method of identification of the need for SBIRT as established during a pre-screening process. • Identification of the screening tool used to conduct the full screening process. • The results of the full screening process. • Brief intervention goals unique to each individual. • Summary report of each brief intervention session conducted, including the implementation of established motivational strategies. • Referrals made and outcomes. • Follow-up services provided. <p>Approved Providers: Coverage of Screening, Brief Intervention, and Referral for Treatment (SBIRT) for pregnant women is covered in conjunction with antepartum care provided by physicians, physician employed nurse practitioners, nurse midwives, physician-employed physician assistants and FQHCs. Prior to offering the services health care professionals must complete an online tutorial which can be accessed at http://www.mh.alabama.gov. The Mental Health and Substance Abuse Services Division of the Alabama Department of Mental Health will notify the Medicaid Maternity Care Program of health care professionals' successful completion of the tutorial. Procedure codes H0049 (screening for substance use) and H0050 (brief intervention and referral to treatment) will then be billable for the health care professional who has successfully completed the online tutorial. An ICD-10 code of Z331 must be billed by the provider on the claim form.</p>
Referral to Specialists	<p>DHCPs may provide referrals to specialists. Services provided by non-OB specialty physicians (i.e. cardiologists, endocrinologists) for problems complicated or exacerbated by pregnancy can be billed fee-for-service by the provider of service. A general/family practitioner is not considered a specialty provider. A Board Certified Perinatologist is considered a specialty provider and may bill fee-for-service for high risk patients only. Refer to the Chapter 28, Physicians Chapter, for billing information.</p>
Non-Pregnancy Related Care	<p>Services provided that are not pregnancy-related may be billed fee-for-service. A recipient's age, health care requirements, and place of residence may further define his or her eligibility for Medicaid covered services. For this reason, it is very important that the providers verify recipient eligibility and ensure they understand all aspects of the eligibility response.</p> <p>A provider may reference the fee schedules for a list of covered services on the following link: http://medicaid.alabama.gov/content/Gated/7.3G_Fee_Schedules.aspx. The fee schedules are not an all-inclusive list of procedure codes covered by the Agency. Reference Chapter 4, Obtaining Prior Authorization (PA) for PA requirements.</p>
Tobacco Cessation Face-To-Face Counseling	<p>The Alabama Medicaid Agency covers smoking cessation benefits for Medicaid-eligible pregnant women. Medicaid will reimburse for up to four face- to-face counseling sessions in a 12-month period. The reimbursement period will begin in the prenatal period and continue through the postpartum period (60 days after delivery or pregnancy end). Documentation must support each counseling session.</p> <p>Face-to-face counseling services must be provided:</p> <ul style="list-style-type: none"> • By or under the supervision of a physician; • By other health care professionals who are legally authorized to furnish such services under State law and within their scope of practice and who is authorized to provide Medicaid coverable services other than tobacco cessation services.

<p>Long Acting Reversible Contraception (LARC)</p>	<p>Refer to Appendix Q Tobacco Cessation for additional information.</p> <p>Effective for dates of service June 4, 2019, and thereafter Alabama Medicaid will reimburse the cost of the long acting reversible contraceptive to the facility when provided in the inpatient hospital setting immediately after a delivery or up to the time of the inpatient discharge for postpartum women, or in an outpatient setting immediately after discharge from the inpatient hospital for postpartum women. The insertion of the device/drug implant will be billable to Medicaid by both the physician and hospital for reimbursement.</p> <p>Refer to Chapter 19 Hospital for additional information. For questions regarding hospital billing contact Solomon Williams, Associate Director, Institutional Services Program at (334) 353-3206 or via e-mail at Solomon.williams@medicaid.alabama.gov For questions regarding physician billing contact Elizabeth Huckabee, Associate Director, Physicians Program, at (334) 242-2312 or via email Elizabeth.huckabee@medicaid.alabama.gov</p>
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40.40 Prior Authorization and Referral Requirements

DHCPs may provide referrals to specialists. Referrals to specialty providers for a pregnant recipient (i.e., Cardiology, Endocrinology, etc.) are paid fee-for-service.

Reference Chapter 4, Obtaining Prior Authorization (PA) for PA requirements.

40.40.1 DHCP SELECTION REFERRAL REQUIREMENTS

All maternity claims must have a DHCP selection referral number from the ACHN to receive payment from Medicaid. Although DHCPs will already have the ACHN NPI number, it is the responsibility of the DHCP to ensure a referral is in the proper payment is made to DHCPs for maternity services.

Exception: Medicaid Recipients that are not assigned to an ACHN on the date of service will not require a DHCP referral from the ACHN for reimbursement.

NOTE:

In emergency circumstances, maternity claims submitted with an emergency indicator (Certified Emergency – Service Authorization Exception Code – 3) will not require a DHCP referral from an ACHN for reimbursement.

Sample ACHN DHCP Referral Form

**Alabama Coordinated Health Network
Delivering Healthcare Professional Selection Referral Form**

ACHN's Name: _____ ACHN's NPI Number: _____

Date: _____

Type of Referral: Initial Change of DHCP High-Risk/Specialty Other _____

Medicaid Eligible Individual (EI) Information

Name:

Last _____ First _____ MI _____

Medicaid Number: _____ DOB: _____

Address: _____

Telephone Number (with area code): _____

40.41 Spontaneous Abortions

Spontaneous abortions do not require a DHCP referral number from the ACHN. However, the DHCP should notify the ACHN when a pregnancy ends due to a spontaneous abortion.

40.42 Cost Sharing (Copayment)

Copayment does not apply to pregnancy-related services provided for pregnant women, but a relevant pregnancy or postpartum diagnosis code must be on the claim.

40.43 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When filing a claim on paper, a CMS-1500 claim form is required.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

40.43.1 *Time Limit for Filing Claims*

Medicaid requires all claims from DHCPs to be filed within one year of the date of service. Refer to Chapter 5, Filing Claims, for more information regarding timely filing limits and exceptions.

40.43.2 DHCP Selection Referral Number

All maternity claims must have a DHCP selection referral number from the ACHN to receive payment from Medicaid. When filing an electronic claim using Medicaid's web portal, the DHCP Selection Referral Number should be entered into the "referring physician" field. If using a vendor/clearinghouse software, the provider will need to confirm with the vendor on where to enter the DHCP selection referral number.

NOTE:

If you use a billing software to submit claims and are not currently set up to insert the referring provider information, you may contact the EMC Helpdesk at 1-800-456-1242 for assistance in getting the software setup properly.

For paper claim submissions, the DHCP selection referral number should be entered as follows:

- **CMS-1500 Claims-** enter the name of the referring ACHN in block 17. Enter the secondary ID (Medicaid ID) in block 17A. The secondary ID may not always be necessary. Enter the ACHN's Referral Number (NPI) in block 17B.
- **UB-04 Claims-** Enter the ACHN's Referral Number (NPI) in block 78.

40.43.3 Diagnosis Codes

A pregnancy or postpartum diagnosis code, primary or secondary, must be used when billing maternity care services.

The *International Classification of Diseases - 10th Revision - Clinical Modification* (ICD-10-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, AMA Plaza 330 North Wabash Ave, Suite 39300 Chicago, IL 60611-5885, or 1-800-621-8335.

NOTE:

ICD-10 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

40.43.4 Procedure Codes, Modifiers, and Rates

DHCPs are to bill all claims to Gainwell utilizing the appropriate CPT code. The following DHCP reimbursement table conveys ACHN delivery rates (effective 10/1/2019) for rural and urban delivery procedure codes:

Alabama Coordinated Health Network (ACHN) Primary Care Physician (PCP) and Delivering Healthcare Professional (DHCP) Billing

Code	Modifier	Description	ACHN Rural	ACHN Urban
59400	U9	Routine obstetric care including antepartum care, vaginal delivery (delivery at 39 weeks of gestation or later) (with or without episiotomy or forceps) and postpartum care	\$1,790	\$1,390
59400	UD	Routine obstetric care including antepartum care, vaginal delivery (medically necessary delivery prior to 39 weeks of gestation) (with or without episiotomy or forceps) and postpartum care	\$1,790	\$1,390
59400	UC	Routine obstetric care including antepartum care, vaginal delivery (non-medically necessary prior to 39 weeks of gestation) (with or without episiotomy or forceps) and postpartum care	\$1,790	\$1,390
59409	U9	Vaginal delivery only (delivery at 39 weeks of gestation or later) (with or without episiotomy and/or forceps)	\$1,340	\$1,040
59409	UD	Vaginal delivery only (medically necessary delivery prior to 39 weeks of gestation) (with or without episiotomy and/or forceps)	\$1,340	\$1,040
59409	UC	Vaginal delivery only (non-medically necessary delivery prior to 39 weeks of gestation) (with or without episiotomy and/or forceps)	\$1,340	\$1,040
59410	U9	Vaginal delivery (delivery at 39 weeks of gestation or later) and postpartum care only	\$1,390	\$1,090
59410	UD	Vaginal delivery (medically necessary delivery prior to 39 weeks of gestation) and postpartum care only	\$1,390	\$1,090
59410	UC	Vaginal delivery (non-medically necessary prior to 39 weeks of gestation) and postpartum care only	\$1,390	\$1,090
59510	U9	Routine obstetric care including antepartum care, cesarean delivery (delivery at 39 weeks of gestation or later) and postpartum care	\$1,790	\$1,390
59510	UD	Routine obstetric care including antepartum care, cesarean delivery (medically necessary delivery prior to 39 weeks of gestation) and postpartum care	\$1,790	\$1,390
59510	UC	Routine obstetric care including antepartum care, cesarean delivery (non-medically necessary prior to 39 weeks of gestation) and postpartum care	\$1,790	\$1,390
59514	U9	Cesarean delivery only (medically necessary delivery prior to 39 weeks of gestation)	\$1,340	\$1,040
59514	UD	Cesarean delivery only (medically necessary delivery prior to 39 weeks of gestation)	\$1,340	\$1,040

Code	Modifier	Description	ACHN Rural	ACHN Urban
59514	UC	Cesarean delivery only (non-medically necessary delivery prior to 39 weeks of gestation)	\$1,340	\$1,040
59515	U9	Cesarean delivery (delivery at 39 weeks of gestation or later) and postpartum care only	\$1,390	\$1,090
59515	UD	Cesarean delivery (medically necessary delivery prior to 39 weeks of gestation) and postpartum care only	\$1,390	\$1,090
59515	UC	Cesarean delivery (non-medically necessary delivery prior to 39 weeks of gestation) and postpartum care only	\$1,390	\$1,090
59610	U9	Routine obstetric care including antepartum care, vaginal delivery (delivery at 39 weeks of gestation or later) (with or without episiotomy and/or forceps) and postpartum care, after previous cesarean delivery	\$1,790	\$1,390
59610	UD	Routine obstetric care including antepartum care, vaginal delivery (medically necessary delivery prior to 39 weeks of gestation) (with or without episiotomy and/or forceps) and postpartum care, after previous cesarean delivery	\$1,790	\$1,390
59610	UC	Routine obstetric care including antepartum care, vaginal delivery (non-medically necessary delivery prior to 39 weeks of gestation) (with or without episiotomy and/or forceps) and postpartum care, after previous cesarean delivery	\$1,790	\$1,390

Medicaid will reimburse maternity services to FQHCs and RHCs via PPS rates and Fee-For-Service rates. PPS rates will be reimbursed for antepartum visits using evaluation and management codes. All other procedure codes for maternity will be billed fee-for-service as described in the table below:

Procedure Code	Description
59409	Vaginal Delivery
59430	Post-Delivery Care
59514	Cesarean Delivery
59612	Vaginal Delivery after Cesarean Delivery
59618	Routine Obstetric Care following Attempted Vaginal Delivery After previous cesarean delivery
59620	Cesarean Delivery After Vaginal Delivery Attempt Due to Prior Cesarean Delivery

NOTE:

Nurse Midwives will be reimbursed 80% of the physician rate.

Rural rates apply to the county location of the DHCP's offices. A map showing urban and rural counties for providers may be accessed on the Medicaid website at www.medicaid.alabama.gov, then select the ACHN tab, ACHN Providers, Medicaid's Designated Urban and Rural Map.

Added: DHCP

DHCP Bonus Payments:

Medicaid will pay \$100.00 for each Bonus Payment and the following procedure codes must be submitted on a separate claim:

- Initial Prenatal Visit – H1000 (if made within 90 days of the last menstrual period)
- Postpartum visit – G9357 (if made between 21 and 56 days of delivery)
(To receive payment for G9357, a paid delivery claim must be in the system)
 - If a provider files procedure code G9357 between 21 and 56 days of delivery and receives a denial, the provider may submit an override request. The override request must be sent to:

Added: (To receive payment...in the system)

**Alabama Medicaid Agency
Managed Care Division
Attention: Linda White
501 Dexter Avenue
P.O. Box 5624
Montgomery, AL 36103-5624**

Added: Only one (1)...the same pregnancy.

Only one (1) initial and/or postpartum DHCP bonus payment will be paid per recipient per pregnancy. Duplicate DHCP bonus payments will not be paid for the same recipient during the same pregnancy.

Nurse Practitioners, Physician Assistants, and Nurse Midwives will receive 80% of the physician rate for these Bonus Payments. These Bonus Payments also apply to FQHCs and RHCs. Medicaid recipients that are not enrolled in the ACHN program on the date of service are not eligible for the prenatal nor the postpartum visit bonus payments. Refer to section 40.22 for a list of ACHN eligible and non-eligible recipients.

NOTE:

Non-citizens are not eligible for the initial prenatal (H1000) nor the postpartum visit (G9357) bonus payments. Claims billed for non-citizens using the mentioned procedure codes will be denied.

Deleted: five

Claims:

The (837) Professional and Institutional electronic claims and the paper claim have been modified to accept up to four Procedure Code Modifiers. Claims for maternity care services are limited to the following procedure codes and modifiers:

NOTE:

Claims that are submitted for obstetric delivery procedure codes **59400, 59409, 59410, 59510, 59514, 59515, 59610, 59612, 59614, 59618, 59620, or 59622** will require one of the following modifiers:

U9-Delivery at 39 weeks of gestation or later

UD-Medically necessary delivery prior to 39 weeks of gestation

UC-Non-medically necessary delivery prior to 39 weeks of gestation

Claims for deliveries that are submitted without one of the required modifiers will be denied.

Appropriate Use of Modifiers

Please refer to this CMS link for more information regarding NCCI edits:

<https://www.medicaid.gov/medicaid/program-integrity/ncci/edit-files/index.html>

Modifier 25 (Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service)

It may be necessary to indicate that on the day a procedure or service identified by CPT code was performed, the patient's condition required a significant, separately identifiable E&M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E&M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E&M service to be reported.

Reimbursement for Services

Global/delivery-only fees paid by Medicaid to the DHCP represent payment in full. **Recipients may not be billed for any services covered under this program.**

NOTE:

Providers are to bill the delivery only procedure codes for pregnant non-citizens.

High Risk Transfers/Reimbursement Methodology

Routine maternity care services provided to a recipient by a Delivering Healthcare Professional before and after the transfer of a recipient to a teaching physician as defined in Section 4,19-B of the State Plan or to a Medicaid enrolled Board Certified Perinatologist will be reimbursed **fee-for-service**. Perinatologists will not require a DHCP referral when billing for ultrasounds appending the 26 modifier.

NOTE:

Refer to Chapter 28, Physician, 28.2.11 Obstetrical and Related Services for general criteria regarding maternity services provided by teaching physicians.

40.43.5 **Place of Service Codes**

The following place of service code applies when filing claims for maternity care services:

<i>POS Code</i>	<i>Description</i>
11	Office
21	Inpatient Hospital

40.44 **Reporting Parity and Gravidity for DHCPs**

The Medicaid Agency uses the American College of Obstetricians and Gynecologists (ACOG) definition for parity and gravidity. According to ACOG, gravidity is defined as the number of pregnancies, current and past, regardless of the pregnancy outcome. ACOG’s definition of parity is the number of pregnancies reaching 20 weeks and 0 days of gestation or beyond, regardless of the number of fetuses or outcomes. In cases of multiple pregnancies, parity is only increased with birth of the last fetus.

Hence, parity cannot be greater than gravida. DHCPs should adhere to the ACOG’s current definitions to report consistent information. For additional information on ACOG’s definitions, visit the following link:

<https://www.acog.org/practice-management/health-it-and-clinical-informatics/revitalize-obstetrics-data-definitions>

40.45 **For More Information**

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

Resource	Where to Find It
Becoming a Medicaid Provider	Chapter 2
Verifying Recipient Eligibility	Chapter 3
Obtaining Prior Authorization	Chapter 4
CMS-1500 Claim Filing Instructions	Chapter 5
Medical Necessity/Medically Necessary Care	Chapter 7
Physicians	Chapter 28
Long Acting Reversible Contraception (LARC)	Chapter 19
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N
Tobacco Cessation	Appendix Q

40.46 Contact Information Summary

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

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

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

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

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

ACHN forms may be requested on Medicaid's website at www.medicaid.alabama.gov.

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

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