Provider Insider

Alabama Medicaid Bulletin — October 2013

10/04/13 • 10/18/13 • 11/01/13 • 11/15/13 • 12/06/13 • 12/13/13
01/03/14 • 01/17/14 • 02/07/14 • 02/21/14 • 03/07/14 • 03/21/14 • 04/04/14 • 04/18/14
As always, the release of direct deposits and checks depends on the availability of funds.

Agency Employs Multiple Strategies to Save Money, Preserve Access

By employing a combination of financial, clinical and administrative strategies, Alabama Medicaid officials hope to cut approximately $11 million in state dollars from its pharmacy program in FY 2014 while still providing access to most critical medications for more than 600,000 Medicaid recipients who qualify for drug coverage each year.

The first cost-cutting measures were implemented July 1 and included reimbursement changes for compounded drugs, increased co-payments on drugs and a change to prevent stockpiling of medications via early refills. The three measures are estimated to save about $1 million in state funds during the 2014 fiscal year.

The next round of changes will start October 1 and include an end to coverage of most over-the-counter drugs. Other measures set to begin on October 1 are a change to the Agency's "lower of" payment methodology and expanded efforts of the Agency's Drug Utilization Review board. Prescription drug limits and a mandatory three-month supply for certain drugs used to treat selected chronic diseases will be phased in to begin January 1, 2014. Together they are projected to save $11.1 million during FY 2014.

One of the most visible changes will be the limit on prescription drugs for adults and a mandatory dispensing of a three month supply of certain drugs. Adult recipients will be limited to a total of five drugs per month, four of which may be brand-name drugs. However, recipients who require anti-psychotic, anti-epileptic (seizure) and/or anti-retroviral (HIV/AIDS) drugs will be allowed to have up to 5 additional (10 total) brand-name or generic versions of these drugs per month.

Additionally, the Agency is phasing in the drug limits to allow prescribers, pharmacists and recipients to find the best schedule for the recipient, according to Director of Clinical Services and Support, Kelli Littlejohn, Pharm.D.

"While the prescription limit for adults may be challenging, the Agency is also implementing a mandatory three-month supply of certain medications for chronic disease states such as hypertension, diabetes, depression, asthma, thyroid disease, and high cholesterol as well as contraceptives," she said. "The three month supply will only be applied to the recipient's prescription limit during the month in which the drug is dispensed, however. Not only will this provide flexibility for the recipient, we also hope that this will benefit recipients who may have transportation or other barriers to timely refills."

Article continued on page 2

In This Issue

Pass It On!

Everyone needs to know the latest about Medicaid. Be sure to route this to:

- ❒ *Office Manager*
- ❒ *Billing Department*
- ❒ *Medical/Clinical Professionals*
- ❒ *Other* _____

EPSDT Referral on Inpatient (UB-04) Claim Form

An EPSDT-referring provider number is not required on an inpatient claim form (UB-04). The A1 condition code **is** required on all inpatient claims that are EPSDT referred.

Vaccines for Children Update

The following vaccines have been added to the VFC list in Appendix A:

90672 Influenza Virus Vaccine, quadrivalent, live, for intranasal use effective 08/01/13 (0-18 years).

90685 Influenza Virus Vaccine, quadrivalent, Split Virus, Preservative Free, when administered to children 6-35 months of age, for intramuscular use effective 7/01/2013 (age 6-35 months).

90686 Influenza Virus Vaccine, quadrivalent, Split Virus, Preservative Free, when administered to individuals 3 years of age and older, for intramuscular use effective 7/01/2013 (age 3-18 years).

Summary of Changes - Medicaid Pharmacy Program

- **July 2013**
  - o Compounding Changes
    - Compounding time no longer reimbursed
    - Most bulk products not covered for adults
    - Change in how claims for bulk powders are submitted
    - Maximum $200 payment for compounded products without prior approval
  - o Increased co-payments for drugs based on drug cost
    - From 50 cents - $3, to 65 cents - $3.90)
  - o Edits to prevent stockpiling of drugs via early refills
- **October 2013**
  - o Phase-in period for Prescription Drug Limit for adults begins
  - o Phase-in period for Three Month supply for certain drugs begins
  - o End coverage of OTC drugs for adults and children (Insulin and Nutritionals excluded)
  - o Expansion of Agency's Drug Utilization Review Board activities
  - o Change to Agency's "lower of" reimbursement method so that Wholesale Acquisition Cost (WAC) is changed from WAC+9.2% to WAC+0%
- **January 2014**
  - o Prescription Drug Limit for adults goes into effect
    - Five total drugs per month, four of which may be brand-name drugs
    - Up to five additional (10 total) for brand-name and generic anti-psychotic, anti-epileptic (seizure) and/or anti-retroviral (HIV/AIDS) drugs

Attention Patient 1st Providers

If you are enrolled as a group provider to receive your Patient 1st assignments or if you are a physician not part of a group and enrolled with Medicaid individually, you may now log on to the Medicaid Secure Website and change a recipient's Patient 1st doctor. The secure website is available at the following location: **https://www.medicaid.alabamaservices.org/ALPortal/Account/Secure%20Site/tabId/66/Default.aspx.** This site may be linked from the Medicaid website using the drop-down menu under Providers.

Providers should then access the following path: **providers/PMP assignment**
A recipient's Medicaid number, or name and date of birth or date of birth and SSN must then be entered to request the change. The same criteria for patient's assignments must still be met. Providers will have the capability to override panel holds, age restrictions, and gender restrictions set by the PMP. The provider's PMP panel must be open, and the caseload not be met at the time the assignment is being made. Providers will not be allowed to override the following restrictions in addition to some other restrictions:

Recipient is locked into another physician (Not a Patient 1st assignment)
Recipient has been previously dismissed from PMP attempting to make the assignment
Requesting provider is not a Patient 1st participating provider
PMP panel at contractual maximum limit
Recipient is not currently eligible for the Patient 1st program

If the change is made by the 15th of the month, the effective date of the Patient 1st change will be the 1st day of the next month. If made after the 15th, it will be effective the following month. This eliminates the need to fax or e-mail Patient 1st change requests to HP Enterprise Services, and assures you the change has been made. In the future, the system will be modified so that all Patient 1st providers will be able to access the Medicaid Secure Website to make Patient 1st changes. Providers will be notified when modifications are completed. If you have any questions, please contact Provider Assistance Center at 1-800-688-7989.

Revised Form 340B (Medicaid/Medicare Related Claim Form)

When submitting Medicare/Medicaid related claims that MUST be sent on paper, effective October 28, 2013, providers must use a revised copy of Form 340B. The forms are available through HP Enterprise Services at no charge by calling 1-800-688-7989.

The following fields are changing:
Section 2 Other Insurance Information-added fields for TPL information
Section 3 Diagnosis Codes Expanded to 12 fields (A-L)
Section 4 Version Indicate version of diagnosis code, ICD-9 /ICD-10
Section 5 F Mod Providers may now enter up to 4 modifiers
Section 5 G DIAG PTR Providers may now enter up to 4 diagnosis pointers on a line item

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

MEDICAL
MEDICAID/MEDICARE
RELATED CLAIM

1. RECIPIENT INFORMATION

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

2. OTHER INSURANCE INFORMATION

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

3. DIAGNOSIS CODES

A._____ B._____ C._____ D._____ E._____ F._____
G._____ H._____ I._____ J._____ K._____ L._____

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

5. DETAIL OF SERVICES PROVIDED

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

It is not necessary to attach Medicare EOMB to this claim unless claim dates of service are over one year old AND Medicare payment is less than 120 days old.

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

Submit completed claim to:

HP
Post Office Box 244032
Montgomery, AL 36124-4032

9. Billing Provider mailing address required in block below:

Form 340 Revised 10/12

Form ALTPL-01 10/12 Medicaid Other Insurance Attachment

When providers submit a claim on paper for a recipient with other insurance and a payment has been made, effective October 28, 2013 providers must use the Medicaid Other Insurance Attachment form (ALTPL-01). The TPL attachment form has been created for submitting paper claims and reporting the following other payer information: paid amount, deductible amount, coinsurance amount and co-pay amount. This form will be required with the CMS 1500 form when third party applies to a claim. The forms are available free of charge and may be ordered by calling the Provider Assistance Center at 1-800-688-7989.

When Should This Attachment Be Used?
This attachment should only be used when a provider must submit a claim on paper and the provider needs to submit information regarding the amounts processed by the other payer: paid amount, deductible amount, coinsurance amount, co-pay amount (For example, third party PAID or applied all the allowed charges to patient responsibility but an administrative review is needed on the claim). **Please remember, Medicaid requires claims be submitted electronically unless an administrative or manual review is required. The majority of these claims will continue to be submitted electronically.**

Claims with third party denials should continue to be submitted in this fashion:
• Indicate TPL denial on the claim in the appropriate block/form locator (for example, Block 19 of CMS-1500 claim form)
• Attach TPL denial to the error free claim for processing

Providers are now able to submit more claims electronically when the other payer paid **or when the other payer applied the charges to patient responsibility.** A provider can now submit a claim for TPL electronically when the other payer pays zero, but the patient responsibility is greater than zero. This can include:

- If any amount greater than zero is entered in the other payer co-pay field, and/or
- If any amount greater than zero is entered in the other payer deductible field, and/or
- If any amount greater than zero is entered in the other payer coinsurance field

In order for claims with TPL to be considered for payment, the patient responsibility must be greater than zero. Patient responsibility is calculated by adding together any co-payments, co-insurance and deductible. Claims that do not contain a patient responsibility will deny with error status code 631 (TPL Patient Responsibility is Zero for Payer). When calculating payment methodology for claims with TPL primary, Medicaid will pay the lesser of patient responsibility or Medicaid allowed amount minus TPL paid amount for professional claims only. All other claim types will continue to price as usual at this time. If you have any questions, please contact the Provider Assistance Center at 1-800-688-7989.

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

MEDICAID
OTHER INSURANCE ATTACHMENT

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

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

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

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

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

Submit completed claim to:

HP
Post Office Box 244032
Montgomery, AL 36124-4032

Form ALTPL-01 10/12

PERM Reviews Are Underway

The Payment Error Rate Measurement (PERM) program measures improper payments in Medicaid and the State Children's Health Insurance Program (SCHIP) and produces state and national-level error rates for each program. PERM audits authorized by the Centers for Medicare & Medicaid Services (CMS) are underway for FY13. APlus Government Solutions, CMS PERM contractor, has begun requesting medical records from providers. If contacted by APlus, it is very important for providers to comply with the requests and submit documentation in a timely manner. Providers should ensure records are legible and complete (i.e. physician signatures, correct dates, treatments plans, progress notes, etc.). For questions, please contact Patricia Jones (334) 242-5609, PERM Program Manager.

Synagis® Criteria for 2013-2014 Season

ATTENTION ALL PROVIDERS:

- The Alabama Medicaid Agency has updated its prior authorization criteria for the Synagis® 2013-2014 season. Below are some highlights for the season. Complete criteria can be found on the website at the following link:

  http://medicaid.alabama.gov/CONTENT/4.0_Programs/4.5.0_Pharmacy/4.5.14_Synagis.aspx

- The approval time frame for Synagis® will begin October 1, 2013 and will be effective through March 31, 2014.
- Up to five doses will be allowed per recipient in this time-frame. Some recipients may only receive up to a max of 3 doses, depending on the gestational and chronological age.
- There are no circumstances that will result in approval of a sixth dose.
- If a dose was administered in an inpatient setting, the date the dose was administered must be included on the request form.
- For approval of requests, the recipient must meet gestational and chronological age requirements. In order to meet chronological age requirements, the recipient must not exceed the specified age at the start of the RSV season.
- Prescribers, not the pharmacy, manufacturer or any other third party entity, are to submit requests for Synagis® on a separate prior authorization form (Form 351) directly to Health Information Designs and completed forms may be accepted beginning September 3, 2013 (for an October 1 effective date).
- Stamped or copied physician signatures will not be accepted and will be returned to the provider.
- A copy of the hospital discharge summary from birth or documentation of the first office visit with pertinent information (gestational age, diagnosis, etc.) is required on all Synagis® PA requests.
- If approved, each subsequent monthly dose will require submission of the recipient's current weight and last injection date and may be faxed to HID by the prescribing physician or dispensing pharmacy utilizing the original PA approval letter.
- Letters will be faxed to both the prescriber and the dispensing pharmacy notating approval or denial.

CRITERIA

Alabama Medicaid follows the 2012 American Academy of Pediatrics (AAP) Redbook guidelines regarding Synagis® utilization. Additional questions regarding Synagis® criteria can be directed to the Agency's Prior Authorization contractor, Health Information Designs at 1-800-748-0130.

ICD-10 Information for Providers Using Medicaid Interactive Web Portal to Submit Claims

Alabama Medicaid is planning to implement ICD-10 coding changes as early as October 28, 2013, but will not require nor accept ICD-10 codes until the federal mandate date of October 1, 2014. When Alabama Medicaid implements changes related to ICD-10, providers will be able to view ICD-10 diagnosis codes when performing diagnosis and surgical procedure code searches in the Medicaid Interactive Web Portal. ICD-10 codes should not be submitted on claims until you are instructed to begin using them. Submitting a claim with an ICD-10 code before the federal mandate date will cause your claims to deny.

Upcoming NCCI Edits for Evaluation-and-Management Services Billed with Surgical Procedures

On October 1, 2013 the Medicaid National Correct Coding Initiative (NCCI) will add over 300,000 Procedure-to-Procedure (PTP) edits that pair some evaluation-and-management (E&M) CPT codes in the code ranges 99201 - 99499 and 92002 - 92014 as column two codes with all surgical procedure codes (over 5,000 codes). These edits were implemented in the Medicare NCCI program on July 1, 2013.

Ordering/Referring Provider's NPI Must Be Present on Claims

Effective October 1, 2013

Code of Federal Regulations (42 CFR 455.440) requires all claims for the payment of items and services that are ordered, referred, or prescribed to contain the National Provider Identifier (NPI) of the physician or other professional who ordered, referred, or prescribed such items or services.

Effective for claims received on or after October 1, 2013, all Medicaid claims from laboratories, imaging centers, X-ray clinics, home health agencies, and durable medical equipment providers MUST have the NPI of the ordering/referring provider. If the ordering/referring provider operates at more than one location, the legacy Medicaid number should also be provided and will be a required entry for proper claims processing.

There are three basic requirements:

1. The physician or non-physician practitioner must be en rolled in Medicaid as either a regular Medicaid provider or as an OPR provider.
2. The NPI used must be for an individual physician or non-physician practitioner and cannot be an organizational NPI.
3. Interns and non-licensed residents must use the NPI of the teaching, admitting, or supervising physician on the claim for reimbursement. If the resident has a medical license, then the resident must be enrolled with Medicaid and the NPI of the resident must be used on the claim for reimbursement.

Attention Physicians and Non-physician Practitioners:

You must furnish your NPI on all orders/referrals for laboratory, imaging services, home health services, and durable medical equipment.
The laboratory facility, the radiology/imaging center, the pharmacy, the home health agency, and the medical supply company will always need the NPI of an ordering/prescribing/referring physician or non-physician practitioner in order to submit their claims for payment to the Medicaid program.

An enrollment application is available for those providers who do not treat Alabama Medicaid recipients for payment, but who do order, prescribe, or refer. These providers will be enrolled as an OPR provider. Medicaid will not make payment to an OPR provider but will recognize their NPI for services rendered by participating Medicaid providers. An abbreviated enrollment application is located on the Alabama Medicaid Agency website at the following link in the Administrative Forms section:

http://medicaid.alabama.gov/CONTENT/5.0_Resources/5.4_Forms_Library/5.4.6_Provider_Enrollment_Forms.aspx

Providers can check to see if an ordering or referring provider is enrolled with Medicaid through the Medicaid Secure Website. Providers may search using an NPI or license number of a provider. This is available on the Providers/Provider Search tab using the following link. **https://www.medicaid.alabamaservices.org/ALPortal/Account/Secure%20Site/tabId/66/Default.aspx**

ATTENTION: HOSPICE PROVIDERS

REMINDER: Claims Processing for the Hospice Program

For a dually eligible recipient in a nursing home, if financially eligible, the hospice provider is on the Level of Care panel. Medicaid reimburses the hospice provider, for every day service is rendered, 95% of the nursing home rate applicable for that year for the room and board that would have been paid to the nursing home (Revenue Code 659/Procedure Code T2046-SE). Hospice bills Medicare for routine care services.

New Information on Eligibility Requests To Display

Affordable Care Act (ACA) Section 1104 requires standards be applied in the eligibility verification response (271) in order to enable the determination of an individual's eligibility benefits and financial responsibility for specific services prior to or at the date of service.

Effective October 28, 2013, providers will now have the option of viewing all recipient eligibility information (information currently displayed) or specifying certain types of coverage information. Additionally, copayment information will also display for providers. ***As always, providers should check eligibility PRIOR to rendering any services.*** Currently, the eligibility response returns the benefit plan information and limitation information. This information will continue to be returned, but will be modified to accept and process multiple service type codes.

Providers need to refer to the specific chapter in their billing manuals for coverage restrictions, as not all services are covered for all recipients. Providers should refer to the billing manual for:

- Copayment exemptions
- Copayment exceptions
  - o The maximum copayment amount will display for the benefit type selected
- The information displayed is general coverage information and general copayment requirements.

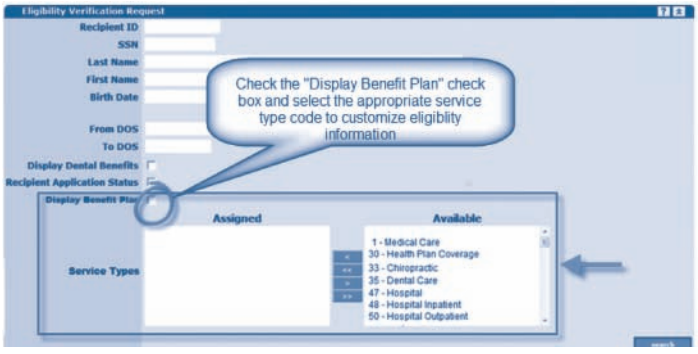
For providers that have varying copayments amounts, refer to the provider manual for specific information.

If you use a vendor to check recipient eligibility, please contact your software vendor regarding the changes and how they affect your office.

Medicaid Interactive Web Portal Changes for Eligibility Requests

If you use Medicaid's Interactive Web Portal, the following information is changing:

Providers will now see additional information displayed on the eligibility verification request panel. (See below). If a provider wants to view all information as they currently do, DO NOT check the box next to 'Display Benefit Plan'. If a provider wants to customize the eligibility information, then check the box and select the most appropriate service type code.

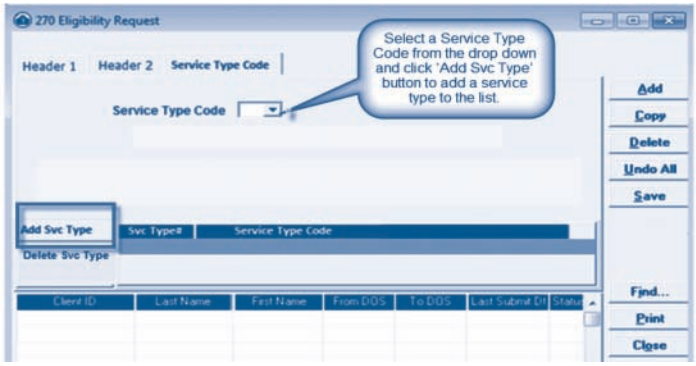


Copayment information will be returned regardless of the service type code selected

Provider Electronic Solutions Changes for Eligibility Requests

If you use Provider Electronic Solutions to verify eligibility, the following information is changing:

A new "Service Type Code" tab is available on the Eligibility Verification Request form. If a provider does not access this tab during the eligibility process, then ALL information for eligibility will display. If a provider accesses this tab, they may customize the type of service codes they wish to view.



Automated Voice Response System Changes for Eligibility Requests

Providers will be able to select the service type codes they wish to retrieve, or select 30 for information currently displayed.

Generic Service Type Codes for Eligibility Requests

A **generic** inquiry request is defined as a request for eligibility information for the service type – 30 (Health Benefit Plan Coverage). Medicaid is adopting the ACA standard codes only, which include:

Codes continued on page 8

Svc Type Code	Description
1	Medical Care
30	Health Benefit Plan Coverage
33	Chiropractic
35	Dental Care
47	Hospital
48	Hospital - Inpatient
50	Hospital - Outpatient
86	Emergency Services
88	Pharmacy
98	Professional (Physician) Visit -office
AL	Vision (Optometry)
MH	Mental Health
UC	Urgent Care

Alabama Medicaid Bulletin

Post Office Box 244032
Montgomery, AL 36124-4032

PRSRT STD
U.S. POSTAGE
PAID
PERMIT # 77
MONTGOMERY AL

Explicit Service Type Codes for Eligibility Requests

An **explicit** inquiry request is defined as a request for eligibility information for any service type other than 30. The service type codes associated with an explicit request are listed here:

If you have questions, please contact the Provider Assistance Center at 1-800-688-7989.

Svc Type Code	Description
1	Medical Care
2	Surgical
4	Diagnostic X-Ray
5	Diagnostic Lab
6	Radiation Therapy
7	Anesthesia
8	Surgical Assistance
12	Durable Medical Equipment Purchase
13	Facility
18	Durable Medical Equipment Rental
20	Second Surgical Opinion
33	Chiropractic
35	Dental Care
40	Oral Surgery
42	Home Health Care
45	Hospice
47	Hospital
48	Hospital - Inpatient
50	Hospital - Outpatient
51	Hospital - Emergency Accident
52	Hospital - Emergency Medical
53	Hospital - Ambulatory Surgical
62	MRI/CAT Scan
65	Newborn Care
68	Well Baby Care
73	Diagnostic Medical

Svc Type Code	Description
76	Dialysis
78	Chemotherapy
80	Immunizations
81	Routine Physical
82	Family Planning
86	Emergency Services
88	Pharmacy
93	Podiatry
98	Professional (Physician) Visit - Office
99	Professional (Physician) Visit - Inpatient
A0	Professional (Physician) Visit - Outpatient
A3	Professional (Physician) Visit - Home
A6	Psychotherapy
A7	Psychiatric Inpatient
A8	Psychiatric Outpatient
AD	Occupational Therapy
AE	Physical Medicine
AF	Speech Therapy
AG	Skilled Nursing Care
AI	Substance Abuse
AL	Vision (Optometry)
BG	Cardiac Rehabilitation
BH	Pediatric
MH	Mental Health
UC	Urgent Care