28

28 Physician

Physician's services, whether furnished in the office, the recipient's home, a hospital, a skilled nursing facility, or elsewhere, refer to services provided by a physician:

- Within the scope of practice of medicine or osteopathy as defined by state law; and
- By or under the personal supervision of an individual licensed under state law to practice medicine of osteopathy.

The policy provisions for physicians can be found in the *Alabama Medicaid Agency Administrative Code,* Chapter 6.

28.1 Enrollment

EDS enrolls physicians and issues provider contracts to applicants who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code*, and the *Alabama Medicaid Provider Manual*. For the purpose of enrollment, a physician is defined as: a physician who is fully licensed and possesses a current license to practice medicine.

EDS also enrolls Physician Assistants (PA), Certified Registered Nurse Practitioners (CRNP), Certified Registered Nurse Anesthetists (CRNA), and Anesthesiology Assistants (AA) who are employed by a Medicaid enrolled physician. Physician-employed includes physicians practicing in an independent practice or in a group practice relationship.

Refer to Chapter 38, Anesthesiology, for more information on CRNA and AA services.

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

Provider Number, Type, and Specialty

A provider who contracts with Medicaid as a physician is issued a nine-digit Alabama Medicaid provider number that enables the provider to submit claims and receive reimbursement for physician-related claims.

NOTE:

All nine digits are required when filing a claim.

Physicians are assigned a provider type of 01 (Physician). Physician-Employed Nurse Practitioners or Physician-Employed Physician Assistants are assigned a provider type of 06 (Physician-Employed Practitioners), and Certified Registered Nurse Anesthetists and Anesthesiology Assistants are assigned a provider type of 92 (CRNA).

Valid specialties for physicians and physician-employed practitioners are listed below:

Specialty	***Code***
Allergy/Immunology	03
Anesthesiology	05
Anesthesiology Assistant	N7
Cardiac surgery	S1
Cardiovascular disease	06
Certified Registered Nurse Anesthetist	C3
Cochlear implant team	C9
Colon and rectal surgery	S2
Dermatology	07
EENT	XA
Emergency medicine	E1
Endocrinology	E2
EPSDT	E3
Family practice	08
Gastroenterology	10
General practice	01
General surgery	02
Geriatrics	38
Hand surgery	21
Hematology	H2
Infectious diseases	55
Internal medicine	11
Mammography	M7
Neonatology	N1
Nephrology	39
Neurological surgery	14
Neurology	13
Nuclear medicine	36
Nutrition	40
Obstetrics/Gynecology	16
Oncology	XI
Ophthalmology	18
Oral and maxillofacial surgery	SE
Orthopedic	X6
Orthopedic surgery	20
Otorhinolaryngology	X9
Pathology	22
Pediatrics	37
Physician-Employed Nurse Practitioner	N3
Physician-Employed Physician Assistant	N6
Plastic, reconstructive, cosmetic surgery	24
Primary care provider (not a screening provider but can refer patients)	AE
Proctology	28
Psychiatry	26
Pulmonary disease	29
Radiology	30
Rheumatology	R4
Thoracic surgery	33
Urology	34
Vascular surgery	S4

Enrollment Policy for Physicians

Providers (in-state and out-of-state) who meet enrollment requirements are eligible to participate in the Alabama Medicaid Program. The PA or CRNP must send a copy of the prescriptive authority granted by the licensing board in order for the PA or CRNP to be added to the Provider License File for the purpose of reimbursing the pharmacist for the prescriptions written by the PA or CRNP. This copy must be sent to EDS Provider Enrollment, P.O. Box 241685, AL 36124-1685.

EDS will not enroll physicians having limited licenses unless complete information as to the limitations and reasons are submitted in writing to the Provider Enrollment Unit for review and consideration for enrollment.

28.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations.

Physicians are expected to render medically necessary services to Medicaid patients in the same manner and under the same standards as for their private patients, and bill the Alabama Medicaid Agency their usual and customary fee.

A physician enrolled in and providing services through an approved residency training program will be assigned a pseudo Medicaid license number, but may not bill for services performed as part of the residency training program. A pseudo Medicaid license number is required on written prescriptions issued to Medicaid recipients. To request a pseudo Medicaid license number, please refer to Chapter 2, Becoming a Medicaid provider for additional information.

Written medication prescriptions should have a typed or printed name of the prescriber on the prescription, handwriting should be legible, and the pseudo license number for a resident should be clearly indicated. Pharmacists **must have the physician's license number** prior to billing for prescriptions. Pharmacies shall use the correct physician license number when submitting a pharmacy claim to Medicaid.

Supervising physicians may bill for services rendered to Medicaid recipients by residents enrolled in and providing services through (as part of) an approved residency training program. The following rules shall apply to physicians supervising residents as part of an approved residency training program:

a. The supervising physician shall sign and date the admission history and physical progress notes written by the resident.

b. The supervising physician shall review all treatment plans and medication orders written by the resident.

c. The supervising physician shall be available by phone or pager.

d. The supervising physician shall designate another physician to supervise the resident in his/her absence.

e. The supervising physician shall not delegate a task to the resident when regulations specify that the physician perform it personally or when such delegation is prohibited by state law or the facility's policy.

Payments from Medicaid funds can be made only to physicians who provide the services; therefore, no reimbursement can be made to patients who may personally pay for the service rendered.

Reimbursement may be made to a physician submitting a claim for services furnished by another physician in the event there is a reciprocal arrangement as long as block 19 on the claim identifies the physician who actually furnished the service. Both physicians should be enrolled as Medicaid providers. The reciprocal arrangement may not exceed 14 days in the case of an informal arrangement or 90 continuous days in the case of an arrangement involving per diem or other fee-for-time compensation. Providers participating in a reciprocal arrangement should be enrolled with the Alabama Medicaid Agency.

The physician agrees when billing Medicaid for a service that the physician will accept as payment in full, the amount paid by Medicaid for that service, plus any cost-sharing amount to be paid by the recipient, and that no additional charge will be made. Conditional collections from patients, made before Medicaid pays, which are to be refunded after Medicaid pays, are not permissible. The physician may bill the patient, in addition to the cost-sharing fee, for services rendered when benefit limitations are exhausted for the year or when the service is a Medicaid non-covered benefit. However, the provider (or their staff) must advise each patient prior to services being rendered when Medicaid payment will not be accepted, and the patient will be responsible for the bill. If a provider routinely accepts a Medicaid assignment, he or she may not bill Medicaid or the recipient for a service he or she did not provide, i.e., missed or canceled appointment.

A hospital-based physician-employed by and paid by a hospital may not bill Medicaid for services performed for which the hospital is reimbursed. A hospital-based physician shall bill the Medicaid Program on a CMS-1500, Health Insurance Claim Form or assign their billing rights to the hospital, which shall bill the Medicaid Program on a CMS-1500 form. A hospital-based physician who is not employed by and paid by a hospital may bill Medicaid using a CMS-1500 claim form.

A physician enrolled in a residency training program and whose practice is limited to the institution in which that resident is placed shall not bill Medicaid for services performed therein for which the institution is reimbursed through the hospitals' cost reports. For tracking purposes, these physicians will be assigned pseudo Medicaid license numbers.

Hospital-based physicians are reimbursed under the same general system as is used in Medicare. Bills for services rendered are submitted as follows:

- All hospital-based physicians, including emergency room physicians, radiologists, and pathologists, will bill Medicaid on a CMS-1500 claim form, or assign their billing rights to the hospital, which shall bill Medicaid on a CMS-1500 claim form.
- Physician services personally rendered for individual patients will be paid only on a reasonable charge basis (i.e., claims submitted under an individual provider number on a physician claim form). This includes services provided by a radiologist and/or pathologist.
- Reasonable charge services are: 1) personally furnished for a patient by a physician; 2) ordinarily require performance by a physician and; 3) contribute to the diagnosis or treatment of an individual patient.

NOTE:

If a provider routinely accepts Medicaid assignments, he/she may not bill Medicaid or the recipient for a service he/she did not provide, i.e., "no call" or “no show”.

28.2.1 Physician-Employed Practitioner Services

Medicaid payment may be made for the professional services of the following physician-employed practitioners:

- Physician Assistants (PAs)
- Certified Registered Nurse Practitioners (CRNPs)

Nurse Practitioner is defined as a Registered Professional Nurse who is currently licensed to practice in the state, who meets the applicable State of Alabama requirements governing the qualifications of nurse practitioners.

Physician Assistant means a person who meets the applicable State of Alabama requirements governing the qualifications for assistants to primary care physicians.

All services requiring additional education and training beyond the scope of practice billed by a CRNP/PA must be documented in the approved collaborative agreement from the Board of Medical Examiners (BME) and the Alabama Board of Nursing (ABN) between the practitioner and physician. The only exception is for those “routine” services within the scope of practice approved by the applicable licensing and governing boards. Services billed outside a CRNP/PA scope of practice and/or collaborative agreement are subject to post-payment review.

Medicaid will make payment for services of Physician Assistants (PAs) and Certified Registered Nurse Practitioners (CRNPs) who are legally authorized to furnish services and who render the services under the supervision of an employing physician with payment made to the employing physician. Medicaid will not make payment to the PA or CRNP. Generally, CRNPs and PAs are reimbursed at 80% of the allowed amount for all services except lab and injectables, which should pay at 100%.

The employing physician must be a Medicaid provider in active status.

The PA or CRNP must enroll with Medicaid and receive an Alabama Medicaid provider number with the employing physician as the payee.

Covered services furnished by the PA or CRNP must be billed under the PA’s or CRNP’s name and Alabama Medicaid provider number.

The covered services for PAs and CRNPs are limited to injectable drugs, laboratory services in which the laboratory is CLIA certified to perform, and the CPT codes identified in Appendix O, CRNP & PA Services.

The office visits performed by the PA or CRNP count against the recipient's yearly benefit limitation.

The PA or CRNP may make physician-required visits to nursing facilities.

The PA or CRNP may not make physician-required inpatient visits to hospitals or other institutional settings to qualify for payment to the physician or to satisfy current regulations as physician visits.

The PA or CRNP may provide low complexity or straightforward medical decision-making services in the emergency room or as an assistant at surgery (identified surgical codes only) for reimbursement by Medicaid. See Appendix O for a list of covered services.

The employing-physician need not be physically present with the PA or CRNP when the services are being rendered to the recipient; however, the physician must be immediately available to the PA or CRNP for direct communication by radio, telephone, or telecommunication.

The PA's or CRNP's employing physician is responsible for the professional activities of the PA or CRNP and for assuring that the services provided are medically necessary and appropriate for the patient.

There shall be no independent, unsupervised practice by PAs or CRNPs.

28.2.2 Covered Services

In general, Medicaid covers physician services if the services meet the following conditions:

- Considered medically necessary by the attending physician
- Designated by procedure codes in the Physicians' Current Procedural Terminology (CPT), HCPCS or designated by special procedure codes created by Medicaid for its own use

This table contains details on selected covered services.

Service	***Coverage and Conditions***
Add-on Code	Add-on Code definition in the CPT is recognized and allowed for payment with the appropriate primary code.
Administration Fee	Please refer to Appendix H, Medicaid Physician Drug List, section H.1 (Policy) for information regarding office visits, chemotherapy, and administration fees. Please refer to Appendix A, Well Child Check-Up, Section A.6.1 (Fees) for information regarding the use of designated VFC codes for billing immunization administration fee(s).
Allergy Treatments	Please refer to Appendix H, Medicaid Physician Drug List, section H.1.2 (Chemotherapy Injections) for information.
Anesthesia	Anesthesia is covered. See Chapter 38, Anesthesiology.
Artificial Eyes	Artificial eyes must be prescribed by a physician.
Breathing or Inhalation Treatments	Breathing or inhalation treatments are a covered service. Any medication provided during a breathing treatment (e.g., Albuterol) is considered a component of the treatment charge.
Cardiac Catheterization	Please note that modifier 51 (multiple procedures) should not be utilized with cardiac codes 93501-93533 or 93539-93556.
Cerumen Removal	Code 69210 (which requires skill and use of forceps, suction, or cerumen spoon) is a covered service.
Chemotherapy Administration	Please note code 36823 includes chemotherapy dose calculation/administration by injection into the perfusate. Codes 96408-96425 should not be utilized with codes 96408-96425.
Computerized Axial Tomograph (CAT) Scans	CAT scans are covered as medically necessary.
Chiropractors	Chiropractic services are covered only for QMB recipients and for services referred directly as a result of an EPSDT screening.

Service	***Coverage and Conditions***
Chromosomal Studies	Medicaid can pay for these studies on prospective mothers in an effort to identify conditions that could result in the birth of an abnormal child.
Circumcision	Circumcision of newborns is a covered service. If medically necessary, non-newborn circumcision is covered.
Diet Instruction	Diet instruction performed by a physician is considered part of a routine visit.
Drugs	Non-injectable drugs must be billed by a pharmacy to be covered. Physicians who administer injectable drugs to their patients may bill Medicaid for the cost of the drug by using the procedure code designated by Medicaid for this purpose.
Examinations	Physician visits for examinations are counted as part of each recipient's benefit limit of 14 physician visits per year. Exception: Certified Emergencies. Annual routine physical examinations are not covered except through EPSDT. Refer to Appendix A, EPSDT, for details. Medical examinations for such reasons as insurance policy qualifications are not covered. Physical examinations for establishment of total and permanent disability status if considered medically necessary are covered. Medicaid requires a physician's visit once every 60 days for patients in a nursing facility. Patients in intermediate care facilities for the mentally retarded must receive a complete physical examination at least annually.
Eyecare	Eye examinations by physicians are a Medicaid covered service. Physician visits for eyecare disease are counted as part of each recipient's benefit limit of 14 physician visits per year.
Foot Devices	See Chapter 14, Durable Medical Equipment (DME), for details
Gastric bypass	Covered with prior authorization
Hearing Aids	See Chapter 10, Audiology/Hearing Services, for details.
Hyperbaric Oxygen Therapy	Topically applied oxygen is not hyperbaric and is not covered. HBO therapy should not be a replacement for other standard successful therapeutic measure. Medical necessity for the use of hyperbaric oxygen for more than two months must be prior approved (see Chapter 4, Obtaining Prior Authorization). Physician attendance should be billed using procedure code 99183. Prior approval for HBO for diagnoses not listed below or for treatments exceeding the limitations listed may be submitted to EDS for consideration on an individual recipient basis. Please note that no approval will be granted for diagnoses listed in the exclusion section. Program reimbursement for HBO therapy is limited to that which is administered in a chamber for the diagnoses found in Chapter 19 Hospital, under Outpatient Hyperbaric Oxygen Therapy (HBO).
Hyperalimention Parental TPN IDPN IPN	Please refer to Section 28.2.9 for documentation requirements for parental, TPN, IDPN, and IPN nutrition.

Added:
Hyperalimentation

Immunizations	The Department of Public Health provides vaccines at no charge to Medicaid physicians enrolled in the Vaccines For Children (VFC) Program. Medicaid reimburses administration fees for vaccines provided free of charge through the Vaccines For Children (VFC) Program. Medicaid tracks usage of the vaccine through billing of the administration fee using the appropriate CPT-4 codes. Refer to Appendix A, EPSDT, for more information. The single antigen vaccines may be billed only when medically justified and prior authorized. These vaccines are listed below: • Diphtheria • Measles • Mumps • Rubella Payment for immunizations against communicable diseases for adults will be made if the physician normally charges his patients for this service.
Infant Resuscitation	Newborn resuscitation (procedure code 99440) is a covered service when the baby's condition is life threatening and immediate resuscitation is necessary to restore and maintain life functions. Intubation, endotracheal, emergency procedure (procedure code 31500) cannot be billed in conjunction with newborn resuscitation.
Mammography Diagnostic	Diagnostic mammography is furnished to a man/woman with signs or symptoms of breast disease, or a personal history of breast cancer, or a personal history of biopsy-proven benign breast disease, and includes a physician's interpretation of the results of the procedure. Services are not limited.
Mammography Screening	Furnished to a woman without signs or symptoms of breast disease, for the purpose of early detection of breast cancer, and includes a physician's interpretation of the results of the procedures. Services are limited to one screening mammography every 12 months for women ages 50 through 64.
Medical Materials and Supplies	Costs for medical materials and supplies normally utilized during office visits or surgical procedures are to be considered part of the total fee for procedures performed by the physician and therefore are not generally a separately billable service.
Newborn Claims	Five kinds of newborn care performed by physicians in the days after the child's birth when the mother is still in the hospital may be filed under the mother's name and number or the baby's name and number: 1. Routine newborn care (99431, 99433, and discharge codes 99238 or 99239) 2. Circumcision (54150 or 54160) 3. Newborn resuscitation (99440) 4. Standby services following a caesarian section or a high-risk vaginal delivery. (99360) 5. Attendance at delivery (when requested by delivering physician) and initial stabilization of newborn (99436) Standby services (procedure code 99360) are covered only when the pediatrician, family practitioner, neonatologist, general practitioner, or non-delivering OB/GYN is on standby in the operating or delivery room during a caesarian section or a high-risk vaginal delivery. Attendance of the standby physician in the hospital operating or delivery room must be documented in the operating or delivery report. Use CPT codes when filing claims for these five kinds of care. If these services are billed under the mother's name and number and the infant(s) are twins, indicate Twin A or Twin B in Block 19 of the claim form. Any care other than routine newborn care for a well baby, before and after the mother leaves the hospital, must be billed under the child's name and number.

Newborn Hearing Screening	Inpatient newborn hearing screenings are considered an integral part of inpatient hospital services. Outpatient facility services for newborn hearing screenings are considered non-covered. Limited hearing screen codes 92586 and 92587 (CPT 2002) may be billed in an outpatient setting provided: 1) an infant was discharged prior to receiving the inpatient hearing screen, or 2) an infant was born outside a hospital or birthing center. These codes are reimbursable for audiologists, pediatricians, otolaryngologists, and EENT. Comprehensive hearing screen codes 92585/92588 may be billed for: 1) infants who fail the newborn hearing screening prior to discharge from the hospital, or 2) infants/children fail a hearing screening at any time following discharge. Comprehensive hearing screenings should be performed on infants by three months of age if they failed the newborn hearing screening prior to discharge. Code 92585 is reimbursable for otolaryngologists, audiologists, pediatricians, and EENT. Code 92588 is reimbursable for otolaryngologists, audiologists, pediatricians, EENT, and neurologists.
Obstetrical Services	Refer to Section 28.2.10
Oxygen and Compressed Gas	A physician's fee for administering oxygen or other compressed gas is a covered service under the Medicaid program. Oxygen therapy is a covered service based on medical necessity and requires prior authorization. Please refer to Chapter 14, DME, for more information.
Podiatrist Service	Covered for QMB or EPSDT referred services only. See Chapter 29, Podiatrist, for more details.
Post Surgical Visits	Post-surgical hospital or office visits for conditions directly related to major surgical procedures are covered by the surgical fee. Post-surgical visits cannot be billed separately the day of, or up to 62 days after surgery.
Prosthetic Devices	Internal prosthetic devices (e.g., Smith Peterson Nail or pacemaker) are a covered benefit.
Psychiatric Services	Physician visits for psychiatric services are counted as part of each recipient's benefit limit of 14 physician visits per year. Psychiatric evaluation or testing are covered services under the Physicians' Program if services are rendered by a physician in person and are medically necessary. Psychiatric evaluations are limited to one per calendar year, per provider, per recipient. Psychotherapy visits are included in the office visit limit of 12 visits per calendar year. Office visits are not covered when billed in conjunction with psychotherapy codes. Psychiatric services under the Physicians' Program are confined to use with psychiatric diagnosis (290-319) and must be performed by a physician. Hospital visits are not covered when billed in conjunction with psychiatric therapy on the same day. For services rendered by psychologist, see Chapter 34 for details. Psychiatric day care is not a covered benefit under the Physicians' Program.
Radiation Treatment Management	Radiation treatment management services do not need to be furnished on consecutive days. Up to two units may be billed on the same date of service as long as there has been a separate break in therapy sessions.
Second Opinions	Physician visits for second opinions are counted as part of each recipient's benefit limit of 14 physician visits per year. Optional Surgery: Second opinions (regarding non-emergency surgery) are highly recommended in the Medicaid program when the recipients request them. Diagnostic Services: Payment may be made for covered diagnostic services deemed necessary by the second physician.

Self-inflicted injuries	Self-inflicted injuries are covered.
Surgery	Cosmetic surgery is covered only when prior approved for medical necessity. Examples of medical necessity include prompt repair of accidental injuries or improvement of the functioning of a malformed body member. Elective surgery is covered when medically necessary. Multiple surgeries are governed by the following rules: When multiple or bilateral surgical procedures that add significant time or complexity are performed at the same operative session, Medicaid pays for the procedure with the highest allowed amount and half of the allowed amount for each subsequent procedure. This also applies to laser surgical procedures. Additional payments will not be made for procedures considered to be mutually exclusive or incidental. When multiple and/or bilateral procedures are billed in conjunction with one another that meet the definition of bundled, subset, CPT's "Format of Terminology", and/or comprehensive/component (bundled) codes, then, the procedure with the highest allowed amount will be paid while the lesser procedure will not be considered for payment as the procedure is considered an integral part of the covered service.. Any dressing/compression wrap performed in conjunction with wound debridement is considered part of the debridement services and is not separately covered/billable. Certain procedures are commonly carried out as integral parts of a total service and as such do not warrant a separate charge. When incidental procedures (e.g., excision of a previous scar or puncture of an ovarian cyst) are performed during the same operative session, Medicaid reimburses for the major procedure only. Laparotomy is covered when it is the only surgical procedure performed during the operative session or when performed with an unrelated or incidental surgical procedure. Surgeons performing laparoscopic procedures on recipients where a laparoscopic procedure code (PC) has not been established should bill the most descriptive PC with modifier 22 (unusual procedural services) until the new PC is established. CPT defined Add-on codes are considered for coverage when billed with the appropriate primary procedure code. Effective January 1, 2005, code 69990 (operating microscope) may be paid separately only when submitted with the following CPT codes: 61304-61546, 61550-61711, 62010-62100, 63081-63308, 63704-63710, 64831, 64834-64836, 64840-64858, 64861-64870, 64885-64898, 64905-64907. Certain relatively small surgical procedure codes formally designated in the CPT with an (*) may be billed in addition to an office visit. Additionally, these codes do not carry the global surgical package concept of inclusion of post-operative care within 62 days of the surgery. In the 2004 CPT guidelines the (*) designation has been removed. For reference, these codes are listed the Procedure Codes section in Chapter 28 of the Billing Manual. It is necessary to append the appropriate anatomical modifiers to surgical codes to differentiate between multiple surgeries and sites. Appropriate use of CPT and HCPCs modifiers is required to differentiate between sites and procedures. Please refer to Section 28.5.3 Procedure Codes and Modifiers NOTE: Surgeons are responsible for submitting hard copy hysterectomy and tubal ligation consent forms to EDS at PO Box 244032, Montgomery, AL 36124 Attn: Desiree Nelson.

Surgery, Breast Reconstruction	Breast reconstruction surgery is reimbursable following a medically necessary mastectomy when performed for the removal of cancer. All reconstructive procedures require prior authorization. The term "reconstruction" shall include augmentation mammoplasty, reduction mammoplasty, and mastoplexy. Breast reconstruction surgeries are governed by the following rules: • The reconstruction follows a medically necessary mastectomy for the removal of cancer • The recipient is eligible for Medicaid on the date of reconstruction surgery • The recipient elects reconstruction within two years of the mastectomy surgery • The diagnosis codes used are appropriate • The surgery is performed in the manner chosen by the patient and the physician in accordance with guidelines consistent with Medicare and other third party payers • For more information regarding prior authorization, please refer to Chapter 4 Obtaining Prior Authorization. For more information related to breast prosthesis, please refer to Chapter 14 Durable Medical Equipment.
Therapy	Physician visits for therapy are counted as part of each recipient's benefit limit of 14 physician visits per year. See Rule No. 560-X-6.14 for details about this benefit limit in the *Alabama Medicaid Agency Administrative Code,* Chapter 6. Physical Therapy is not covered when provided in a physician's office. Physical therapy is covered only when prescribed by a physician and provided in a hospital setting. Refer to Chapter 19, Hospital, for more information. Group Therapy is a covered service when a psychiatric diagnosis is present and the therapy is prescribed, performed, and billed by the physician personally. Group Therapy is not covered when performed by a caseworker, social services worker, mental health worker, or any counseling professional other than physician. Group Therapy is included in the physician visit limit of 14 visits per year. Speech Therapy for a speech related diagnosis, such as stroke (CVA) or partial laryngectomy, is a covered benefit when prescribed by and performed by a physician in his office. Speech therapy performed in an inpatient or outpatient hospital setting or in a nursing facility is a covered benefit, but is considered covered as part of the reimbursement made to the facility and should not be billed by the physician. Family Therapy is a covered service when a psychiatric diagnosis is present and the physician providing the service supplies documentation that justifies the medical necessity of the therapy for each family member. Family therapy is not covered unless the patient is present. Family Therapy is not covered when performed by a caseworker, social service worker, mental health worker, or any counseling professional other than a physician. Family Therapy is included in the physician visit limit of 14 visits per year.
Transplants	See Chapter 19, Hospitals, for transplant coverage.
Ventilation Study	Ventilation study is covered if done in physician's office by the physician or under the physician's direct supervision. Documentation in the medical record must contain all of the following: • Graphic record • Total and timed vital capacity • Maximum breathing capacity Always indicate if the studies were performed with or without a bronchodilator.

Well Baby Coverage	Well baby coverage is covered only on the initial visit, which must be provided within eight weeks of the birth. When the well-baby checkup is done, the physician should bill procedure code 99432. Only one well-baby checkup can be paid per lifetime, per recipient. Refer to Appendix A, EPSDT, for information on additional preventive services.

NOTE:

For newborn hospital discharge services performed on a subsequent admission date, use code 99238. Please use code 99435 when filing claims for newborns assessed and discharged from the hospital or birthing room on the same date.

28.2.3 Non-covered Services

Service	***Coverage and Conditions***
Acupuncture	Acupuncture is not covered.
After Office Hours	The following services are not covered: After office hours, services provided in a location other than the physician's office, and office services provided on an emergency basis.
Autopsies	Autopsies are not covered.
Biofeedback	Biofeedback is not covered.
Blood Tests	Blood tests are not covered for marriage licenses.
Casting and Supplies	Some surgical codes are considered an inclusive package of professional services and/or supplies and are not considered separately allowable or reimbursable as the fracture repair or surgical codes is inclusive of these services. An example of this would be a surgical code for a fracture repair which is inclusive of any casting and strapping services or supplies.
Cerumen Removal	When a simple instrument is used, such as a curette, or a solvent or lavage is used, and the cerumen comes out easily, it is considered a component of an evaluation and management charge.
Chiropractors	Chiropractic services are not covered, except for QMB recipients and for services referred directly as a result of an EPSDT screening.
Chromosomal Studies	Chromosomal studies (amniocentesis) on unborn children being considered for adoption are not covered. Medicaid can pay for these studies on prospective mothers in an effort to identify conditions that could result in the birth of an abnormal child.
Dressing and Compression Wrap	Any dressing/compression wrap performed in conjunction with wound debridement is considered part of the debridement services and is not separately covered/billable.
Experimental Treatment or Surgery	Experimental treatment or surgery is not covered.
Filing Fees	Filing Fees are not covered.
Hypnosis	Hypnosis is not covered.
Laetrile Therapy	Laetrile therapy is not covered.
Mutually Exclusive Procedures	Mutually exclusive procedures are those codes that cannot reasonably be done in the same session and are considered not separately allowable or reimbursable. For example, a vaginal and abdominal hysterectomy on the same date of service.
Oxygen and Compressed Gas	A physician's fee for administering oxygen or other compressed gas is a covered service under the Medicaid program; the cost of the oxygen or gas is not covered.

Service	*Coverage and Conditions*
Surgery	When multiple and/or bilateral procedures are billed in conjunction with one another and meet the CPTs definition of "Format of Terminology" (bundled or subset) and/or comprehensive/component (bundled) codes, then the procedure with the highest amount will be paid while the procedure with the lesser amount will not be considered for payment as the procedure is considered an integral part of the covered service. Please refer to Section 28.5.3 Procedure Codes and Modifiers. Incidental surgical procedures are defined as those codes that are commonly carried out as integral parts of a total service and as such do not warrant a separate charge. An example of this would be lysis of adhesions during the same session as an abdominal surgery.
Post Surgical Visits	Post-surgical hospital or office visits for conditions directly related to major surgical procedures are covered by the surgical fee. Post-surgical visits cannot be billed separately one day prior to surgery or up to 62 days after surgery. Visits by Assistant Surgeon or Surgeons are not covered.
Preventive Medicine	Medicaid does not cover preventive medicine other than those specified elsewhere, including but not limited to, EPSDT screening.
Syntocin	Syntocin is not covered.
Telephone Consultations	Telephone consultations are not covered.
Therapy	Occupational and Recreational Therapies are not covered.

28.2.4 Limitations on Services

Within each calendar year each recipient is limited to no more than a total of 14 physician visits in offices, hospital outpatient settings, nursing facilities, rural health clinics or Federally Qualified Health Centers. Visits not counted under this benefit limit will include, but not be limited to, visits for: EPSDT, prenatal care, postnatal care, and family planning. Physicians services provided in a hospital outpatient setting that have been certified as an emergency do not count against the physician benefit limit of 14 per calendar year. If a patient receives ancillary services in a doctor's office, by the physician or under his/her direct supervision, and the doctor submits a claim only for the ancillary services but not for the office visit, then the services provided will not be counted as a visit.

For further information regarding outpatient maintenance dialysis and ESRD, refer to Chapter 35, Renal Dialysis Facility.

A new patient office visit codes shall not be paid to the same physician or same group practice for a recipient more than once in a three-year period.

28.2.5 Physician Services to Hospital Inpatients

In addition to the 14 physician visits, Medicaid covers up to 16 inpatient dates of service per physician, per recipient, per calendar year. For purposes of this limitation, each specialty within a group or partnership is considered a single provider.

When filing claims for recipients enrolled in the Patient 1st Program, please refer to Chapter 39, Patient 1st, to determine whether your services require a referral from the Primary Medical Provider (PMP).

Physician hospital visits are limited to one visit per day, per recipient, per provider.

Physician(s) may bill for inpatient professional interpretation(s), when that interpretation serves as the official and final report documented in the patient's medical record. Professional interpretation may be billed in addition to a hospital visit if the rounding physician also is responsible for the documentation of the final report for the procedure in the patient's medical record. Professional interpretation may not be billed in addition to hospital visits if the provider reviews results in the medical record or unofficially interprets medical, laboratory, or radiology tests. Review and interpretation of such tests and results are included in the evaluation and management of the inpatient. Medicaid will cover either one hospital visit or professional interpretation(s) up to the allowed benefit limit for most services. Professional interpretations are allowed in the inpatient setting for the following services:

Echocardiography (i.e., M-mode, transthoracic, complete and follow up)

Echocardiography (i.e., 2D, transesophageal)

Echocardiography (i.e., Doppler pulsed or continuous wave with spectral display, complete and follow up)

Cardiac Catheterizations

Comprehensive electrophysiologic evaluations and follow up testing

Programmed stimulation and pacing

Intra-operative epicardial and endocardial pacing and mapping

Intracardiac catheter ablations; intracardiac echocardiography

Evaluation of cardiovascular function

Plethysmography, total body and tracing

Ambulatory blood pressure monitoring

Cerebrovascular arterial studies, extremity arterial studies, venous studies, and visceral and penile studies

Circardian respiratory pattern recording (i.e., pediatric pneumogram), infant

Needle electromyography

Ischemic limb exercise test

Assessment of aphasia

Developmental testing

Neurobehavioral status exam and neuropsychological testing battery

Professional interpretations for lab and x-ray (CPT code 70000 through 80000 services) in the inpatient setting can only be billed by pathologists and radiologists. The only exception is for professional interpretations by cardiologists for catheterization or arterial studies and for select laboratory procedures by oncologists and hematologists. Professional interpretations/components done by other physicians for services in this procedure code range are included in the hospital visit if one is done. If no hospital visit is made, professional interpretation by physicians other than radiologists, pathologists, oncologists, hematologists, and cardiologists should not be billed as these services are covered only for the above-mentioned specialties.

A physician hospital visit and hospital discharge shall not be paid to the same physician on the same day. If both are billed, only the discharge shall be paid.

Professional interpretations performed for an inpatient are counted by dates of service rather than the number of interpretation performed.

An office visit and an inpatient visit shall not be paid to the same physician on the same day. If both are billed, then the first Procedure Code billed will be paid.

Physician consults are limited to one per day per recipient.

28.2.6 Critical Care

When caring for a critically ill patient, for whom the constant attention of the physician is required, the appropriate critical care procedure code (99291 and 99292) must be billed. Critical care guidelines are defined in the Current Procedural Terminology (CPT) and Provider Manual. Critical care is considered a daily global inclusive of all services directly related to critical care. These codes can only be billed for a recipient age 25 months and older.

Coverage of critical care may total no more than four hours per day.

The actual time period spent in attendance at the patient's bedside or performing duties specifically related to that patient, irrespective of breaks in attendance, must be documented in the patient's medical record.

RESTRICTIONS:

No individual procedures related to critical care may be billed in addition to procedure codes 99291 and 99292, except:

- An EPSDT screening may be billed in lieu of the initial hospital care (P/C 99221, 99222, or 99223). If screening is billed, the initial hospital care cannot be billed.
- Procedure code 99082 (transportation or escort of patient) may also be billed with critical care (99291 and/or 99292). Only the attending physician may bill this service and critical care. Residents or nurses who escort a patient may not bill either service.

LIMITATIONS:

- Procedure codes 99291 and 99292 may be billed by the physician providing the care of the critically ill or injured patient in place of service 41, Ambulance, if care is personally rendered by the physician providing the care of the critically ill or injured patient.

28.2.7 Pediatric and Neonatal Critical Care

CPT Code	Description	Criteria
99293	Initial Inpatient Pediatric Critical Care, per day, for the evaluation and management of a critically ill infant or young child, 29 days through 24 months of age	Not valid for ages 28 days or less, can be billed by any physician provider type
99294	Subsequent Inpatient Pediatric Critical Care per day, for the evaluation and management of a critically ill infant or young child, 29 days through 24 months of age.	Not valid for ages 28 days or less, can be billed by any physician provider type
99295	Initial Inpatient Neonatal Critical Care, per day for the evaluation and management of a critically ill neonate, 28 days of age or less	Not valid for ages 29 days or older, can be billed by any physician provider type
99296	Subsequent Inpatient Neonatal Critical Care, per day for the evaluation and management of a critically ill neonate, 28 days of age or less	Not valid for ages 29 days or older, can be billed by any physician provider type

The pediatric and neonatal critical care codes (99293-99296) include management, monitoring and treatment of the patient, including respiratory, pharmacological control of the circulatory system, enteral and parenteral nutrition, metabolic and hematologic maintenance, parent/family counseling, case management services and personal direct supervision of the health care team in the performance of their daily activities.

Routinely these codes may include any of the following services, therefore these services should not be billed separately from the critical care codes 99293-99296: umbilical venous or umbilical arterial catheters, central or peripheral vessel catheterization, other arterial catheters, oral or nasal gastric tube placement, endotracheal intubation, lumbar puncture, suprapubic bladder aspiration, bladder catheterization, initiation and management of mechanical ventilation or CPAP, surfactant administration, intravascular fluid administration, transfusion of blood components (excluding exchange transfusions), vascular puncture, invasive or non-invasive electronic monitoring of vital signs, beside pulmonary function testing, and/or monitoring or interpretation of blood gases or oxygen saturation.

The following criteria should be used as guidelines for the correct reporting of neonatal and pediatric critical care codes for the critically ill neonate/infant. Only one criterion is required to be classified as critically ill.

- Respiratory support by ventilator or CPAP
- Nitric oxide or ECMO
- Prostaglandin, Indotropin of Chronotropic or Insulin infusions
- NPO with IV fluids
- Acute Dialysis (renal or peritoneal)
- Weight less than 1,250 grams
- Acute respiratory distress in a pediatric admission requiring oxygen therapy with at least daily adjustment and FIO2>35% oxygen by oxyhood.

RESTRICTIONS:

No individual procedures related to critical care may be billed in addition to procedure codes 99293-99296 except:

- Chest tube placement
- Pericardiocentesis or thoacentesis
- Intracranial taps
- Initial hospital care history and physical or EPSDT screen may be billed in conjunction with 99295. Both may not be billed. NOTE: One EPSDT screen for the hospitalization will encompass all diagnoses identified during the hospital stay for referral purposes.
- Standby (99360), resuscitation (99440), or attendance at delivery (99436) may be billed in addition to critical care. Only one of these codes may be billed in addition to neonatal intensive care critical care codes.

LIMITATIONS:

- Code 99293 (initial inpatient pediatric critical care) is reported for the initial evaluation and management on the first day for infants 29 days through 24 months of age.
- Code 99294 (subsequent inpatient pediatric critical care) is reported for subsequent days (per day) for infants 29 days through 24 months of age.
- Code 99295 (initial inpatient neonatal critical care) is reported for subsequent days (per day) for neonates, 28 days of age or less.

- Code 99296 (subsequent inpatient neonatal critical care) is reported for subsequent days (per day) for neonates, 28 days of age or less.

- Pediatric, neonatal critical care codes and intensive (non-critical) low birth weight service codes are reported once per day per recipient.

- Subsequent Hospital Care codes (99231-99233) cannot be billed on the same date of service as neonatal critical care codes (99293-99296)

- Only one unit of critical care can be billed per child per day in the same facility. Medicaid pays the first claim received and denies subsequent claims (first in, first out policy).

- Critical care is considered to be an evaluation and management service. Although usually furnished in a critical or intensive care unit, critical care may be provided in any inpatient health care setting. Services provided which do not meet critical care criteria, should be billed under the appropriate hospital care codes. If a recipient is readmitted to the NICU/ICU, the provider must be the primary physician in order for NICU critical care codes to be billed again.

- Once the patient is no longer considered by the attending physician to be critical, the Subsequent Hospital Care codes (99231-99233) should be billed. Only one unit can be billed per day per physician regardless of specialty. Medicaid pays the first claim received and denies subsequent claims (first in, first out policy).

- Transfers to the pediatric unit from the NICU cannot be billed using critical care codes. Subsequent hospital care would be billed in these instances.

- Global payments encompass all care and procedures that are included in the rate. Providers may not perform an EPSDT screen and refer to a partner or other physician to do procedures. All procedures that are included in the daily critical care rate, regardless of who performed them, are included in the global critical care code.

- Consultant care rendered to children for which the provider is not the primary attending physician must be billed using consultation codes. Appropriate procedures may be billed in addition to consultations. If, after the consultation the provider assumes total responsibility for care, critical care may be billed using the appropriate critical care codes as defined above. The medical record must clearly indicate that the provider is assuming total responsibility for care of the patient and is the primary attending physician for the patient.

28.2.8 Intensive (Non-Critical) Low Birth Weight Services

CPT Code	Description	Criteria
99298	Subsequent intensive care, per day, for the evaluation and management of the recovering very low birth	May only be billed by a neonatologist
99299	Subsequent intensive care, per day, for the evaluation and management of the recovering very low birth weight infant (present body weight of 1500-2500 grams)	May only be billed by a neonatologist

These codes are used to report care subsequent to the day of admission provided by a neonatologist directing the continuing intensive care of the very low birthweight infant who no longer meets the definition of being critically ill. Low birthweight services are reported for neonates less than 2500 grams who do not meet the definition of critical care but continue to require intensive observation and frequent services and intervention only available in an intensive care setting. Services provided to these infants exceed those available in less intensive hospital areas of medical floors. These infants require intensive cardiac and respiratory monitoring, continuous and/or frequent vital signs monitoring, heat maintenance, enteral and/or parenteral nutritional adjustments, laboratory and oxygen monitoring and constant observation by the health care team under direct supervision.

RESTRICTIONS:

No individual procedures related to critical care may be billed in addition to procedure codes 99298-99299 except:

- Chest tube placement
- Pericardiocentesis or thoracentesis
- Intracranial taps

LIMITATIONS:

- Once the patient is no longer considered by the attending physician to be critical, the Subsequent Hospital Care codes (99231-99233) should be billed. Only one unit can be billed per day per physician regardless of specialty. Medicaid pays the first claim received and denies subsequent claims (first in, first out policy).
- Global payments encompass all care and procedures that are included in the rate. Providers may not perform an EPSDT screen and refer to a partner or other physician to do procedures. All procedures that are included in the daily critical care rate, regardless of who performed them, are included in the global critical care code.

- Consultant care rendered to children for which the provider is not the primary attending physician must be billed using consultation codes. Appropriate procedures may be billed in addition to consultations. If, after the consultation the provider assumes total responsibility for care, critical care may be billed using the appropriate critical care codes as per the setting. The medical record must clearly indicate that the provider is assuming total responsibility for care of the patient and is the primary attending physician for the patient.

- Pediatric, neonatal critical care codes and intensive (non-critical) low birth weight services codes are only reported once per day per recipient.

28.2.9 End-Stage Renal Disease (ESRD)

Physician services rendered to each outpatient maintenance dialysis patient provided during a full month shall be billed on a monthly capitation basis using the appropriate procedure code by age as outlined in the CPT. Monthly maintenance dialysis payment (i.e., uninterrupted maintenance dialysis) is comprehensive and covers most of a physician's services whether a patient dialyzes at home or in an approved ESRD outpatient facility. Dialysis procedures are allowed in addition to the monthly maintenance dialysis payment. In general, the Agency follows Medicare guidelines related to monthly capitation payments for physicians.

Physician services included in the monthly capitation payment for ESRD related services include, but are not limited to:

- Assessment and determination of the need for outpatient chronic dialysis therapy
- Assessment and determination of the type of dialysis access and dialyzing cycle,
- Management of the dialysis visits including outpatient visits for evaluation and management, management during the dialysis, and telephone calls.
- Assessment and determination if a recipient meets preliminary criteria as a renal transplant candidate including discussions with family members
- Assessment for a specified diet and nutritional supplementation for the control of chronic renal failure, including specifying quantity of total protein, sodium, potassium, amount of fluids, types of anemia and appropriate treatments, type of arthropathy or neuropathy and appropriate treatment or referral, estimated ideal dry weight, etc. Assessment for diabetic patient's diet and caloric intake is included also.
- Prescribing the parameters of intradialytic management including anticoagulant, dialysis blood flow rates and temperature, duration and frequency of treatments, etc.

The monthly capitation payment is limited to once per month, per recipient, per provider.

The following services are not covered by the monthly capitation payment (MCP) for the attending dialysis physicians and are reimbursed in accordance with usual and customary charge rules:

- Declotting of shunts
- Covered physician services furnished to hospital inpatients by a physician who elects not to receive the MCP for these service, For example, an attending physician who provides evaluation and management (E & M) services for a renal patient in an inpatient setting may bill appropriate CPT hemodialysis procedures in lieu of certain other E & M services for ipatient visits.
- Nonrenal related physician services furnished by the physician providing renal care or by another physician. (These services may not be incidental to services furnished during a dialysis session or office visit necessitated by the renal condition.) For example, physician services rendered to hospitalized inpatient recipients who require dialysis but are not receiving dialysis on that day may use the appropriate procedure code as described in the CPT.

Physician services are allowed for outpatient maintenance dialysis patients not performed as prescribed during a full month or interruptedly. An example of interrupted monthly outpatient dialysis maintenance is preceding and/or following the period of hospitalization.

The CPT codes described by age for physicians rendering outpatient dialysis services that are interrupted during a full month should be billed on a per day basis. These codes should be billed for the days of the month in which the outpatient ESRD related services were performed.

Single or repeated physician assessments are allowed for hemodialysis or dialysis procedures other than hemodialysis. These services are comprehensive and include assessment and management related to the patient's renal dialysis. Please utilize the most descriptive and appropriate CPT dialysis procedure when billing for single or repeated physician evaluation(s).

Dialysis training is a covered service when billed by an approved ESRD facility.

Refer to Chapter 35, Renal Dialysis Facility, for further details.

Parenteral Nutrition

Added: Parenteral Nutrition

The Alabama Medicaid Agency may reimburse for total parenteral nutritional (TPN) solutions through the pharmacy program if the recipient meets certain requirements as listed below. TPN solutions include those used for hyperalimentation, intradialytic parenteral nutrition (IDPN), and intraperitoneal nutrition (IPN). Requirements must be met and clearly documented in the medical record for coverage of all TPN. All services rendered are subject to post payment review.

Statement of Medical Necessity

Added: Statement of Medical Necessity

The ordering physician will be responsible for writing a statement of medical necessity. This statement shall certify that the patient cannot be maintained on oral or enteral feedings and that due to severe pathology of the alimentary tract either hyperalimentation or IDPN/IPN must be given for 100% of nutritional needs. The original signed statement of medical necessity must be kept in the patient's medical record. This certification statement must be written or stamped on the prescription or reproduced on a form accompanying the prescription. The statement must be signed and dated by the certifying physician at the time of each order.

Hyperalimentation

Added: Hyperalimentation section

Medicaid covers hyperalimentation for recipients who meet certain requirements of medical necessity and documentation in the medical record is sufficient based on the following:

- Documentation in the medical record must validate the patient suffers from a permanently impaired gastrointestinal tract and that there is insufficient absorption of nutrients to maintain adequate strength and weight. The following are considered conditions which could cause insufficient absorption:

  1. Crohn's disease
  2. Obstruction secondary to stricture or neoplasm of the esophagus or stomach
  3. Loss of ability to swallow due to central nervous system disorder, where the risk of aspiration is great
  4. Short bowel syndrome secondary to massive small bowel resection
  5. Malabsorption due to enterocolic, enterovesical or enterocutaneous fistulas (TPN temporary until the repair of the fistula)
  6. Motility disorder (pseudo-obstruction)
  7. Prolonged paralytic ileus following a major surgical procedure or multiple injuries
  8. Newborn infants with catastrophic gastrointestinal anomalies such as tracheoesophageal fistulas, gastroschisis, omphalocele or massive intestinal atresia
  9. Infants and young children who fail to thrive due to systemic disease or secondary to insufficiency associated with short bowel syndrome, malabsorption or chronic idiopathic diarrhea.

- Medical record documentation must include supporting evidence that the patient cannot be maintained on oral or enteral feedings and that due to severe pathology of the alimentary tract, hyperalimentation must be given in order to meet 100% of the patient's nutritional needs.

- Physical signs, symptoms and test results indicating severe pathology of the alimentary tract must be clearly documented in the medical record. This would include BUN, serum albumin, and phosphorus. Medical records must document inability to maintain weight during a trial of at least four weeks of enteral feeding.

Added: Physical signs, symptoms…of enteral feeding

Intradialytic Parenteral Nutrition (IDPN) and Intraperitoneal Nutrition (IPN)

Added: Intradialytic Parenteral Nutrition (IDPN) and Intraperitoneal Nutrition (IPN) section

IDPN and IPN involves infusing hyperalimentation fluids as part of dialysis, through the vascular shunt or intraperitoneally to normalize the amounts of albumin, glucose, and other nutrients in the blood stream to decrease morbidity and mortality associated with protein calorie malnutrition. IDPN and IPN solutions are considered **not covered** for the recipient with a functioning gastrointestinal tract whose need for parenteral nutrition is only due to the following:

- If IDPN or IPN is offered as an addition to regularly scheduled infusions of TPN
- If the recipient would not qualify as a candidate for TPN
- A swallowing disorder
- A temporary defect in gastric emptying such as a metabolic or electrolyte disorder
- A psychological disorder, such as depression, impairing food intake
- A metabolic disorder inducing anorexia, such as cancer
- A physical disorder impairing food intake, such as dyspnea or severe pulmonary or cardiac disease
- A side effect of medication
- Renal failure and/or dialysis

The following requirements must be met in order to bill for IDPN or IPN solutions:

- Documentation in the medical record must validate the patient suffers from a permanently impaired gastrointestinal tract and that there is insufficient absorption of nutrients to maintain adequate strength and weight.
- Documentation must include that the patient cannot be maintained on oral or enteral feedings and that due to severe pathology of the alimentary tract, IDPN or IPN must be given in order to meet 100% of the patient's nutritional needs.

Added: Infusions must be…caused by dialysis.

- Infusions must be vital to the nutritional status of the recipient and not supplemental to a deficient diet or deficiencies caused by dialysis.

Added: Physical signs, symptoms and… of enteral feeding.

- Physical signs, symptoms and test results indicating severe pathology of the alimentary tract must be clearly documented in the medical record. This would include creatinine (predialysis), serum albumin (predialysis), a low or declining serum cholesterol level, and phosphorus. Medical records must document inability to maintain weight during a trial of at least four weeks of enteral feeding.

Added: Restrictions

Restrictions

A few solutions used in TPN preparation are considered payable as part of the composite rate for dialysis and should not be billed separately by the pharmacist; these are as follows:

- Glucose
- Dextrose
- Trace Elements
- Multivitamins

28.2.10 Anesthesiology

Administration of anesthesia is a covered service when administered by or directed by a duly licensed physician for a medical procedure that is covered by Medicaid. Medical direction by an anesthesiologist of more than four Certified Registered Nurse Anesthetists (CRNAs) or Anesthesiology Assistants (AAs) concurrently will not be covered.

Administration of anesthesia by an AA is a covered service when the AA has met the qualifications and standards set forth in Rule No. 540-X-7-.34 of the Alabama Board of Medical Examiners. The AA must enroll and receive a provider number to bill the Alabama Medicaid Program. Refer to Chapter 38, Anesthesiology, for more information.

28.2.11 Obstetrical and Related Services

The following policy refers to maternity care billed as fee-for-service and not as a part of the Maternity Care program. Refer to Chapter 24, Maternity Care Program, for more details.

Physician visits for obstetrical care are counted as part of each recipient's benefit limit of 14 physician visits per year under the conditions listed below.

Maternity Care and Delivery

The services normally provided in maternity cases include antepartum care, delivery, and postpartum care. When a physician provides total obstetrical care, the procedure code which shall be filed on the claim form is the code for all-inclusive "global" care. The indicated date of service on "global" claims should be the date of delivery. If a woman is pregnant at the time she becomes eligible for Medicaid benefits, only those services provided during the time she is eligible will be covered.

NOTE:

When a physician provides eight (8) or more prenatal visits, performs the delivery, and provides the postpartum care, the physician must use a "global" obstetrical code in billing.

If a physician submits a "global" fee for maternity care and delivery, the visits covered by these codes are not counted against the recipient's limit of 14 physician office visits a calendar year. For purposes of "global" obstetrical billing, services rendered by members of a group practice are to be considered as services rendered by a single provider.

NOTE:

The date of service on the “global” OB claim must be the date of delivery.

Antepartum care includes all usual prenatal services such as initial office visit at which time pregnancy is diagnosed, initial and subsequent histories, physical examinations, blood pressure recordings, fetal heart tones, maternity counseling, etc.; therefore, additional claims for routine services should not be filed. Antepartum care also includes routine lab work (e.g., hemoglobin, hematocrit, chemical urinalysis, etc.); therefore, additional claims for routine lab work should not be filed.

To justify billing for global antepartum care services, physicians must utilize the CPT-4 antepartum care global codes (either 4-6 visits or 7 or more visits), as appropriate. Claims for antepartum care filed in this manner do not count against the recipient's limit of 14 office visits per year.

NOTE:

Physicians who provide less than four (4) visits for antepartum care must utilize CPT-4 codes under office medical services when billing for these services. These office visit codes will be counted against the recipient's limit of 14 physician visits a calendar year.

Billing for antepartum care services in addition to "global" care is not permissible. However, in cases of pregnancy complicated by toxemia, cardiac problems, diabetes, neurological problems or other conditions requiring additional or unusual services or hospitalization, claims for additional services may be filed. If the physician bills fragmented services in any case other than high-risk or complicated pregnancy and then bills a "global" code, the fragmented codes shall be recouped. Claims for such services involved in complicated or high risk pregnancies may be filed utilizing CPT codes for Office Medical Services. Claims for services involving complicated or high-risk pregnancies must indicate a diagnosis other than normal pregnancy and must be for services provided outside of scheduled antepartum visits. These claims for services shall be applied against the recipient's limit of 14 physician office visits a calendar year.

Delivery and Postpartum Care

Delivery shall include vaginal delivery (with or without episiotomy) or cesarean section delivery and all in-hospital postpartum care. More than one delivery fee may not be billed for a multiple birth (twins, triplets, etc.) delivery, regardless of delivery method(s). Delivery fees include all professional services related to the hospitalization and delivery which are provided by the physician; therefore, additional claims for physician's services in the hospital such as hospital admission, may not be filed in addition to a claim for delivery or a claim for "global" care.

EXCEPTION: When a physician's first and only encounter with the recipient is for delivery ("walk-in" patient) he may bill for a hospital admission (history and physical) in addition to delivery charges.

Postpartum care includes office visits following vaginal or cesarean section delivery for routine postpartum care within 62 days post delivery. Additional claims for routine visits during this time should not be filed.

Delivery Only

If the physician performs the delivery only, he must utilize the appropriate CPT-4 delivery only code (vaginal delivery only or C-section delivery only). More than one delivery fee may not be billed for a multiple birth (twins, triplets, etc.) delivery, regardless of the delivery method(s). Delivery fees include all professional services related to the hospitalization and delivery which are provided by the physician; therefore, additional claims for physician's services in the hospital such as hospital admission, may not be filed in addition to a claim for delivery only.

EXCEPTION: When a physician's first and only encounter with the recipient is for delivery ("walk-in" patient) he may bill for a hospital admission (history and physical) in addition to delivery charges.

Ultrasounds

Obstetrical ultrasounds are limited to two per pregnancy. For patients covered under the maternity care waiver, refer to Chapter 24, Maternity Care Program. Generally, first ultrasounds are conducted to detect gestational age, multiple pregnancies, and major malformations. Second ultrasounds may be conducted to detect fetal growth disorders (intrauterine growth retardation, macrosomia) and anomalies that would appear later or may have been unrecognizable in the earlier scan.

Additional ultrasounds may be **prior approved** by the Alabama Medicaid Agency if a patient's documented medical condition meets any of the following criteria:

- Gestational diabetes with complications (Type 1 diabetes, vascular disease, hypertension, elevated alpha-fetoprotein values, poor patient compliance)
- Failure to gain weight, evaluation of fetal growth
- Pregnancy-induced hypertension
- Vaginal bleeding of undetermined etiology
- Coexisting adnexal mass
- Abnormal amniotic fluid volume (polyhydramnios, oligohydramnios)

- Pregnant trauma patient
- Congenital diaphragmatic hernia (CDH)
- Monitoring for special tests such as fetoscopy, amniocentesis, or cervical cerclage placement
- Assist in operations performed on the fetus in the uterus
- Detection of fetal abnormalities with other indicators or risk factors (Low human chronic gonadotrophin (HCG) and high-unconjugated estriol (uE3) are predictive of an increased risk for Trisomy 18. Echogenic bowel grades 2 and 3 are indicative of an increased risk of cystic fibrosis and Trisomy 21)
- Determination of fetal presentation
- Suspected multiple gestation, serial evaluation of fetal growth in multiple gestation
- Suspected hydatidiform mole
- Suspected fetal death
- Suspected uterine abnormality
- Suspected abrupt placenta
- Follow-up evaluation of placental location for identified placenta previa
- Maternity Care subcontractors should contact the Primary Contractor for information regarding obstetrical ultrasounds.

To determine if a procedure requires prior authorization, providers should use the AVRS line at EDS, 1-800-727-7848.

28.2.12 Vaccines For Children (VFC)

The Department of Public Health provides vaccines at no charge to Medicaid providers enrolled in the Vaccines For Children (VFC) Program as recommended by the Advisory Committee on Immunization.

Medicaid reimburses administration fees for vaccines provided free of charge through the VFC Program. The rate for the administration fee is $8.00; it is not the rate on the pricing file. Please refer to Appendix A, Well Child Check-Up, Section A.6.1 (Fees) for information regarding the use of designated VFC codes for billing immunization administration fee(s).

A VFC provider may or may not choose to become an enrolled Medicaid provider. Enrollment as a VFC provider or a Medicaid provider is independent of each other.

Refer to Appendix A, EPSDT, for procedure codes for VFC.

28.2.13 Lab Services

Collection of laboratory specimens may be billed only when sending specimens to another site for analysis if the other site is not owned, operated, or financially associated with the site in which the specimen was collected. The collection fee may not be billed if the lab work is done at the same site where the specimen was collected or in a lab owned, operated, or financially associated with the site in which the specimen was collected.

Providers will not be paid for and should not submit claims for laboratory work done for them by independent laboratories or by hospital laboratories.

Providers may submit claims for laboratory work done by them in their own offices or own laboratory facilities. Providers who send specimens to independent laboratories for analysis may bill a collection fee. This fee shall not be paid to any provider who has not actually extracted the specimen from the patient.

NOTE:

Providers should use procedure code 36415-90 for routine venipuncture collection, 36416-90 for collection of capillary blood specimen (e.g., finger, heal, ear stick) and Q0091-90 for collection of Pap smear specimen.

Repeat Lab Procedures
Modifier 91 may be utilized to denote a repeat clinical laboratory test performed on the dame date of service for the same recipient. Providers should use modifier 91 instead of modifier 76 for repeat lab procedures.

NOTE:

A physician CANNOT bill the following pathology/laboratory procedure codes, however the above collection fee can be billed, if applicable:

82775 Galactose – 1 – phosphate uridyl transferase; quantitative
83498 Hydroxyprogesterone, 17 – d
84030 Phenylalanine (PKU) blood
84437 Thyroxine; total requiring elution (e.g., neonatal)

28.2.14 Supply Code

The procedure code 99070 is utilized by physicians to bill for supplies and materials over and above those usually included with the office visit. Examples of supplies and materials over and beyond usual supplies include elastic wraps, disposable tubing for bronchial dilating equipment or post-operative dressing changes when no office visit is allowable.

28.3 Prior Authorization and Referral Requirements

Medical care and services that require prior authorization for in-state providers will continue to require prior authorization for out-of-state providers, e.g., organ transplants and select surgical procedures. Please refer to Chapter 4, Obtaining Prior Authorization for more information.

Unlisted services and procedure codes are not covered by the Alabama Medicaid Agency, with the exception of Medicare crossover claims and rare instances when approval is granted prior to service provision after the agency has determined that the service is covered and that no other procedure code exists for reimbursement.

28.4 Cost Sharing (Copayment)

The copayment amount for physician office visit (including crossovers, and optometric) is $1.00 per visit. Copayment does not apply to services provided for pregnant women, nursing facility residents, recipients less than 18 years of age, emergencies, and family planning.

The provider may not deny services to any eligible Medicaid recipient because of the recipient's inability to pay the cost-sharing (copayment) amount imposed.

28.5 Completing the Claim Form

➢Electronic claims submission can save you time and money. The system alerts you to common errors and allows you to correct and resubmit claims online.

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

Physicians who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

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

NOTE:

When filing a claim on paper, a CMS-1500 claim form is required. Medicare-related claims must be filed using the Medical Medicaid/Medicare-related Claim Form.

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

28.5.1 Time Limit for Filing Claims

Medicaid requires all claims for physicians to be filed within one year of the date of service. Refer to Section 5.1.5, Filing Limits, for more information regarding timely filing limits and exceptions.

28.5.2 Diagnosis Codes

The *International Classification of Diseases - 9th Revision - Clinical Modification* (ICD-9-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, P.O. Box 10950, Chicago, IL 60610.

NOTE:

ICD-9 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

28.5.3 Procedure Codes and Modifiers

Medicaid uses the Healthcare Common Procedure Coding System (HCPCS). HCPCS is composed of the following:

- American Medical Association's Current Procedural Terminology (CPT)
- Nationally assigned codes developed for Medicare
- Locally assigned codes issued by Medicaid. Effective for dates of service on or after 01/01/2004, use national codes.

Filing Claims with Modifiers

Appropriate use of CPT and HCPCs modifiers is required to differentiate between sites and procedures. It is necessary to append the appropriate anatomical modifiers to surgical codes to differentiate between multiple surgeries and sites.

Appropriate Use of Modifiers

Modifier 59 (Distinct Procedural Service)

According to the CPT book, modifier 59 is described as being necessary to describe a distinct procedural service. This modifier should only be used to show a distinct procedural service when a comprehensive/component coding pair is billed. Modifier 59 should not be billed to represent that multiple services of the same procedure code were performed.

A comprehensive/coding pair occurs when one code is considered a component procedure and the other code is considered a comprehensive procedure. These code pairs are frequently referred to as bundled codes thus meaning the component code is usually considered an integral part of the comprehensive code. Therefore, in most instances the most comprehensive code only should be billed and the component code should be denied as rebundled or mutually exclusive.

Modifier 59 should only be used in conjunction with a comprehensive/coding pair procedure when appropriately unbundling the code pair. This modifier 59 should not be billed with the comprehensive code. The component code can be unbundled, or allowed separately, in certain situations. If the two services are performed at two different times of day or the services are performed in two different anatomical sites, then modifier 59 can be submitted with the component procedure code.
In order to communicate the special circumstances of the component/comprehensive code pair unbundling, diagnoses codes and anatomical modifiers must be utilized as appropriate on the claim form. In some cases, it may be necessary to attach a copy of the Operative Report to further explain the reason for the unbundling of code pairs.

Modifier 59 should never be used in any other circumstances and is subject to post payment review. If the services performed and billed for a date of service does not include a coding pair described above, then modifier 59 is not valid or appropriate.

NOTE:

Modifier 59 is not to be used with Physician's Current Procedural Terminology (CPT) codes 99201-99499 or 77419-77430.

Modifier 76 (Repeat Procedure)

Prior to January 1, 2004, providers were advised to file multiple services with modifiers Y2-Y9 and Z2-Z3 to avoid services being denied as duplicates. Since these modifiers have been eliminated, we are revising instructions for filing multiple services that are performed on the same day. . The appropriate use of CPT and HCPCS codes is required when filing claims. In addition, *diagnosis codes* and *modifiers* should assist with accurately describing services billed. It is necessary to append the appropriate anatomical modifiers to procedure codes to differentiate between multiple sites. If a claim drops for manual review, the appropriate use of *diagnosis codes* and *modifiers* may assist claim reviewers in determining the intent of billing without having to request documentation. As always, providers can continue to file modifiers RT and LT when two of the same procedure is performed and one is on the right side and one is on the left side of the body. However, if more than one service is performed on the right or left side, services could be denied as duplicates if more than one RT or LT modifier is filed on the same procedure code. Modifier 76 is defined by the CPT as "Repeat Procedure by Same Physician". Therefore, we are providing the following instructions to educate providers on how to submit those services.

1) If multiple services are performed, anatomical modifiers can be filed in addition to modifier 76 on the second line item. Anatomical modifiers are: LT, RT, E1-E4, F1-F9, FA, T1-T9, and TA.

Date of Service	Place	Procedure	Number of Services
2/4/03-2/4/03	11	73580-RT	1
2/4/03-2/4/03	11	73580-RT76	1

2) If multiple services are performed, anatomical modifiers can be used without modifier 76.

Date of Service	Place	Procedure	Number of Services
2/4/04-2/4/03	11	28820-T8	1
2/4/03-2/4/03	11	28820-TA	1

Multiple services (excluding most surgeries) can also be filed with multiple units of service. Modifier 76 is defined as "repeat procedure by same physician". The Agency requires claims filed with multiple units of service be submitted as shown below.

3) The first line must be submitted with only one unit of service and the second line with modifier 76 can show the additional number of services that were performed that day.

Date of Service	Place	Procedure	Number of Services
2/4/03-2/4/03	11	88305-TC	1
2/4/03-2/4/03	11	88305-TC76	3

Modifier 50 (Bilateral Procedures)

Modifier 50 represents a bilateral service was performed. For example, if bilateral joint injections are administered into the shoulders, the services should be filed as follows:

Date of Service	Place	Procedure	Number of Services
2/4/03-2/4/03	11	20610-50	1

There should be only one line item submitted with modifier 50, one unit of service and a submitted amount to cover both procedures. The modifier 50 instructs our system to pay for the procedure with the highest allowed amount and half of the allowed amount for each subsequent procedure.

Procedure Codes

The CPT manual lists most procedure codes required by Medicaid. This manual may be obtained by contacting the Order Department, American Medical Association, 515 North State Street, Chicago, IL 60610-9986. The (837) Professional electronic claim and the paper claim have been modified to accept up to four Procedure Code Modifiers.

NOTE:
Unlisted procedure codes are not covered by the Agency unless the provider requested and received approval for a prior authorization before the service is rendered. The Agency will deny all requests for payment of unlisted codes after the fact.

Physician-Employed Physician Assistants (PA) and Certified Registered Nurse Practitioners (CRNP)

Payment will be made only for physician drugs identified in Appendix H, Alabama Medicaid Physician Drug List, CPT codes identified in Appendix O, CRNP and PA Services, and laboratory services, which are CLIA certified. EPSDT screenings will be covered only if the provider is enrolled in that program. Refer to Appendix A, EPSDT, for EPSDT program requirements.

The Physician's Assistant or CRNP can make physician required inpatient visits to nursing facilities. However, physician required inpatient visits to hospitals or other institutional settings cannot be made by a PA or CRNP. Also, the PA or CRNP may provide low complexity or straightforward medical decision-making services in the emergency room or assist at surgery (identified surgical codes only) for Medicaid reimbursement.

Surgical Procedure Codes Not Included in Global Surgical Package

Certain relatively small surgical procedure codes formally designated in the CPT with an (*) may be billed in addition to an office visit. Additionally, these codes do not carry the global surgical package concept of inclusion of post-operative care within 62 days of the surgery. In the 2004 CPT guidelines the (*) designation has been removed. For reference, these codes are listed below the covered services section in Chapter 28 of the Billing Manual.

Surgical Procedure Code Modifiers

When submitting claims for procedures done on the same date of service, a modifier is required to indicate that the repeated service is not a duplicate. If the **same** provider performs the repeat procedure, use modifier 76.

For repeat procedures done on the same date of service by a **different** provider, use modifier 77. Claims submitted for repeat procedures on the same date of service without modifiers are denied as duplicate services.

Modifier	*Description*
76	Repeat Procedure By Same Physician. Modifier indicates a procedure of service is repeated by the same physician subsequent to the original service. This situation may be reported by adding modifier 76 to the five-digit procedure code.
77	Repeat Procedure By Another Physician modifier indicates that a basic procedure performed by another physician had to be repeated. This situation may be reported by adding modifier 77 to the five-digit procedure code.
59	Distinct procedural service modifier indicates that a service or procedure was distinct or separate from other services performed on the same day. This may represent a different session or patient encounter, different procedure or surgery, different site, separate lesion, or separate injury (or area of injury in extensive injuries).

Procedure Codes		
10040	36000	58100
10060	36405	58300
10080	36406	58340
10120	36410	58350
10140	36415	59000
10160	36440	59020
11000	36470	59030
11200	36471	60000
11300	36488	61000
11305	36489	61001
11310	36490	61020
11730	36491	61026
11900	36510	61050
11901	36600	61055
12001	36660	61070
12002	38300	61105
12004	40800	61107
12011	40804	61210
12013	41000	62268
12031	41005	62269
12032	41250	62270
12041	41251	62272
12051	41252	62273
15786	41800	62280
16020	42000	62281
16025	42300	62282
17000	42310	62284
17110	42320	62290
17250	42400	62291
17260	42650	64400

Procedure Codes		
17270	42660	64402
17280	42700	64405
17340	43450	64408
17360	43760	64410
17380	45900	64412
19000	45905	64413
19100	45915	64415
20000	46030	64417
20206	46050	64418
20500	46080	64420
20501	46320	64421
20520	46900	64425
20525	46910	64430
20550	47000	64435
20600	48102	64445
20605	49080	64450
20610	49081	64505
20650	49180	64508
20665	49400	64510
20670	49420	64520
21100	50200	64530
21315	50390	65205
21355	50398	65210
23700	50688	65220
24640	51000	65222
27086	51005	65270
27256	51600	65410
27257	51700	65430
27275	51705	65435
27605	51710	65800
27860	53600	65805
28001	53601	66030
28002	53620	67500
28190	53621	67515
28630	53660	67700
28635	53661	67710
28660	54050	67715
28665	54055	67810
30000	54200	67820
30020	55000	67825
30200	55100	67840
30210	56405	67850
30300	56420	68135
30560	56605	68200
30801	56606	68440
30901	56720	68801
30903	57020	68810
30905	57100	68840
30906	57150	68850
31000	57160	69000
31002	57400	69020
32000	57410	69420
32400	57452	69421
32420	57454	69433

Procedure Codes	
32960	57500
33010	57511
33011	57800

Professional and Technical Components

Some procedure codes in the 70000, 80000, 90000, and G series are a combination of a professional component and a technical component. Therefore, these codes may be billed one of three different ways; (1) as a global, (2) as a professional component, or (3) as a technical component. NOTE: Not all providers are allowed to bill any or all of the three ways to bill. Specific coverage questions should be addressed to the Provider Assistance Center.

- **Global**, the provider must own the equipment, pay the technician, review the results, and provide a written report of the findings. The procedure code is billed with no modifiers. The Global component should be billed only for the following place of service locations:
  - 11 (Office)
  - 81 (Independent Laboratory)
- **Professional component**, the provider does not own or operate the equipment. The provider reviews the results, and provides a written report of the findings. The Radiological professional component is billed by adding modifier 26 to the procedure code, and should be billed only for the following place of service locations:
  - 21 (inpatient hospital)
  - 22 (outpatient hospital)
  - 23 (emergency room - hospital)
  - 51 (inpatient psychiatric facility)
  - 61 (comprehensive inpatient rehab facility)
  - 62 (comprehensive outpatient rehab facility)
  - 65 (end-stage renal disease facility)
  - 81 (Independent Laboratory)
- **Technical component**, the provider must own the equipment, but does not review and document the results. The technical component charges are the facility's charges and are not billed separately by physicians. The technical component is billed by adding modifier TC to the procedure code. The technical component can only be billed by facilities.

28.5.4 Billing for Patient 1st Referred Service

Please refer to Chapter 39 for information regarding the Patient 1st Program and Patient 1st referrals. Please refer to Chapter 5, Filing Claims, for information regarding filing claims for a Patient 1st referral.

28.5.5 Place of Service Codes

The following place of service codes apply when filing claims for physicians:

POS	*Description*
11	Office
12	Home
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room - Hospital
24	Ambulatory Surgical Center
25	Birthing Center
26	Military Treatment Facility
31	Skilled Nursing Facility or Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
34	Hospice
41	Ambulance - Land
42	Ambulance - Air or water
51	Inpatient Psychiatric Facility
52	Psy. Fac. Partial Hospitalization
53	Community Mental Health Center
54	Intermediate Care Fac./Mentally Retarded
55	Residential Substance Abuse Treatment Facility
56	Psychiatric Residential Treatment Center
61	Comprehensive Inpatient Rehabilitation Facility
62	Comprehensive Outpatient Rehabilitation Facility
65	End Stage Renal Disease Treatment Facility
71	State or Local Public Health Clinic
72	Rural Health Clinic

28.5.6 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to the following circumstances:

- Claims With Third Party Denials

NOTE:

When an attachment is required, a hard copy CMS-1500 claim form must be submitted.

Refer to Section 5.7, Required Attachments, for more information on attachments.

28.5.7 Consent Forms Required Before Payments Can Be Made

NOTE:

EDS will NOT pay any claims to ANY provider until a correctly completed original of the appropriate form is on file at EDS.

Abortions

In accordance with federal law, abortions are covered only (1) if the pregnancy is the result of an act of rape or incest; or (2) where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.

Please refer to Appendix E, Medicaid Forms, for a copy of the PHY-96-2 Certification and Documentation for Abortion form, which is used when the pregnancy is causing the life of the mother to be in danger. In the case of abortions performed secondary to pregnancies resulting from rape or incest, the documentation required is a letter from the recipient or provider certifying that the pregnancy resulted from rape or incest.

- The original copy of the PHY-96-2 form (for life of the mother in danger) signed by the attending physician, or the certification letter regarding rape or incest, and a copy of the medical records (history and physical, operative report and discharge summary) must be submitted to EDS.
- The second copy of the consent form or certification letter must be placed in the recipient's medical record.
- Copies of the consent form or certification letter may need to be provided to hospital, laboratory or other providers as applicable in order for them to submit billing for their services.

All claims relating to abortions must have the above-specified documentation on file at EDS prior to payment.

This documentation is not required when a recipient presents with a spontaneous abortion.

If the recipient does not qualify for payment by Medicaid and elects to have the abortion, providers may bill the recipient for the abortion as a non-covered service.

Sterilization

EDS must have on file the Medicaid-approved sterilization form. Refer to Appendix C, Family Planning, for more information.

Sterilization by Hysterectomy

Payment is not available for a hysterectomy if:

1. It was performed solely for the purpose of rendering an individual permanently incapable of reproducing
2. If there was more than one purpose to the procedure, it would not have been performed but for the purpose of rendering the individual permanently incapable of reproducing

Hysterectomy procedures performed for the sole purpose of rendering an individual incapable of reproducing are not covered under Medicaid. Hysterectomies done as a medical necessity as treatment of disease can be paid for by the Medicaid funds under the physician's program.

NOTE:

Sterilization performed for the sole purpose of rendering a person permanently incapable of reproducing is not available to persons under twenty-one (21) years of age under the Medicaid Program.

Refer to Appendix E, Medicaid Forms, for a sample of the sterilization form.

Hysterectomy

The hysterectomy consent form was recently revised. The form was revised to include a section for unusual circumstances. Now this form can be used by a physician to certify a patient was already sterile when the hysterectomy was performed; a hysterectomy was performed under a life threatening situation; or a hysterectomy was performed under a period of retroactive Medicaid eligibility. In all of these circumstances, medical records must be forwarded to EDS along with the hysterectomy consent form and claim(s) in order for a State review to be performed.

NOTE:

The **doctor's explanation** to the patient that the operation will make her sterile and the **doctor's and recipient's signature** must precede the operation except in the case of medical emergency.

It is also important to note that certain fields on the hysterectomy consent form are non-correctable. The non-correctable fields include the recipient's signature and date of signed informed consent, the provider's signature and date of informed consent and the representative's signature and date of informed consent (if the recipient requires a representative to sign for them). If a non-correctable field is missing, contains invalid information or indicates the recipient/representative or physician signed after the date of surgery, EDS will deny the consent form.

EDS must have on file a Medicaid-approved Hysterectomy Consent Form. The revised hysterectomy consent form (form # PHY-81243) becomes effective January 1, 2004. Instructions for completing the consent form will be on the back of the consent form. See Appendix E, Medicaid Forms, or visit our website for a sample copy of this form.

Please note, only the surgeon should submit a hysterectomy consent form to EDS. All other providers should not request and submit copies of the consent form. Multiple copies slow down the consent form review and claims payment process.

Exceptions That Do Not Require Consent

If the following situations, the consent form is not required. If consent is not required, **the reason must be stated on the claim.**

1. The physician who performed the hysterectomy certifies in writing that the patient was already sterile when the hysterectomy was performed; the cause of sterility must be stated in this written statement.

2. The physician who performed the hysterectomy certifies in writing that the hysterectomy was performed under a life-threatening emergency situation in which prior acknowledgement was not possible. This written statement must include a description of the nature of the emergency.
3. The hysterectomy was performed during a period of retroactive Medicaid eligibility, and the physician who performed the hysterectomy submits, in lieu of the consent form, a written statement certifying that the individual was informed before the operation that the hysterectomy would make her sterile.

NOTE:

Medicaid payment cannot be made for any claims for services provided in connection with an abortion, a sterilization procedure or a hysterectomy for medical reasons unless an approved consent form is on file. Please be aware consent for sterilization is different from consent for hysterectomy. See Appendix M, Medicaid Forms, for examples of each.

28.6 For More Information

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

Resource	Where to Find It
CMS-1500 Claim Filing Instructions	Section 5.2
Medical Medicaid/Medicare-related Claim Filing Instructions	Section 5.6.1
Anesthesiology	Chapter 38
EPSDT	Appendix A
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
Family Planning	Appendix C
Alabama Medicaid Injectable Drug List	Appendix H
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N
CRNP and PA Services	Appendix O

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